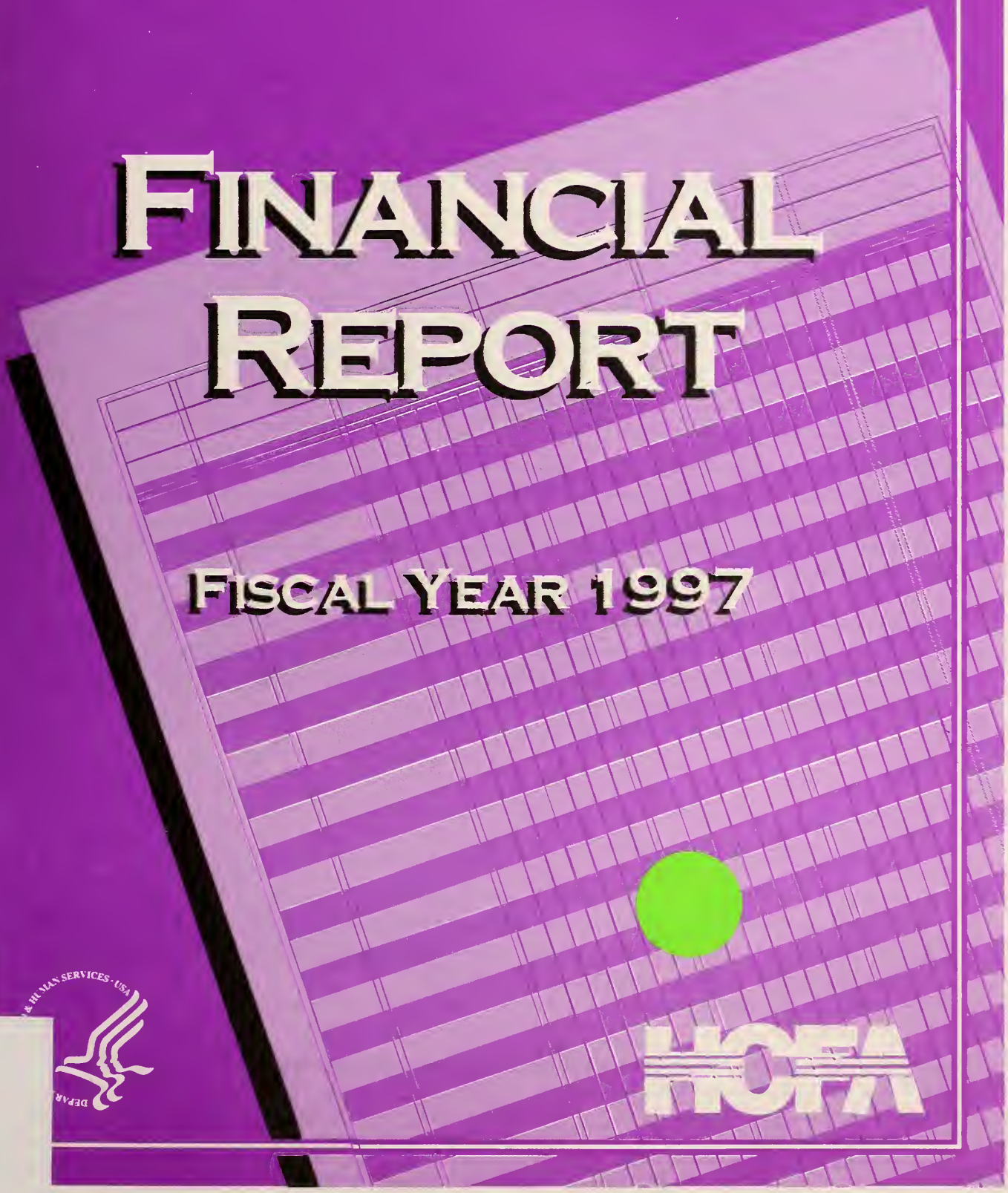
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

FINANCIAL REPORT

FISCAL YEAR 1997



HCFA

U.S. Department of Health and Human Services
Donna E. Shalala, Secretary

Health Care Financing Administration
Nancy-Ann Min DeParle

THE Chief Financial Officers (CFO) Act of 1990 (P.L. 101-567) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompaning report.

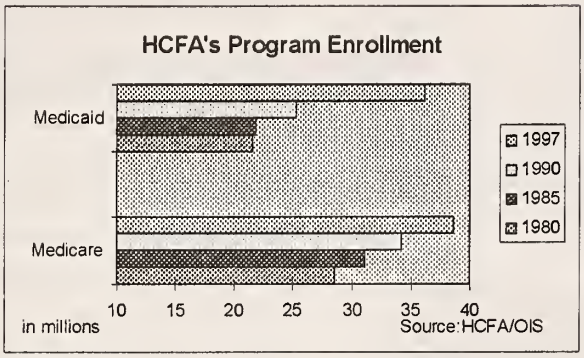
The form and content of this Financial Report follow guidelines provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects HCFA's strong support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

NOTE: This report was modified from its original release to include data from the 1998 Annual Report of Trustees for the Health Insurance Trust Fund and the 1998 Annual Report of Trustees for the Supplementary Medical Insurance Trust Fund.

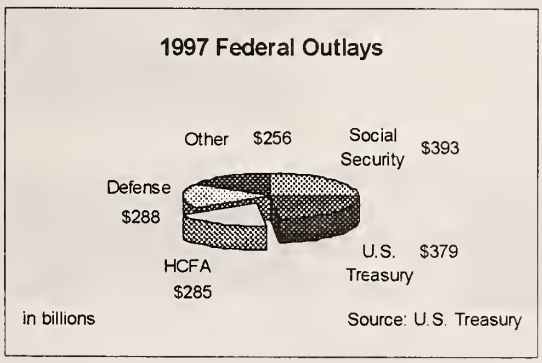
U.S. Department of Health and Human Services
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244

The Health Care Financing Administration AT A GLANCE

➤HCFA celebrated the 31st Anniversary of the Medicare and Medicaid programs in 1997. Over the past 31 years, Medicare enrollment increased from 19.5 million beneficiaries in 1967 to 38.6 million beneficiaries today. Recipients of Medicaid services increased from 10 million beneficiaries in 1967 to 36.2 million beneficiaries. We cover one in four Americans.

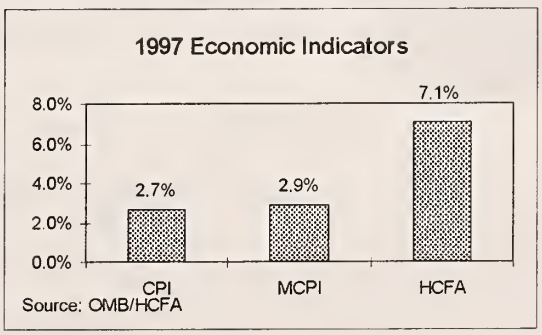


➤HCFA has 4,000 Federal employees; 2,620 are headquartered in Baltimore and Washington, and 1,380 work in 10 cities around the country. HCFA is responsible for safeguarding the fiscal integrity of Medicare and Medicaid, assuring the safety and quality of medical facilities, providing health insurance protections to workers changing jobs, and maintaining the largest collection of health care data in the United States. HCFA and its contractors pay more than 800 million Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries.

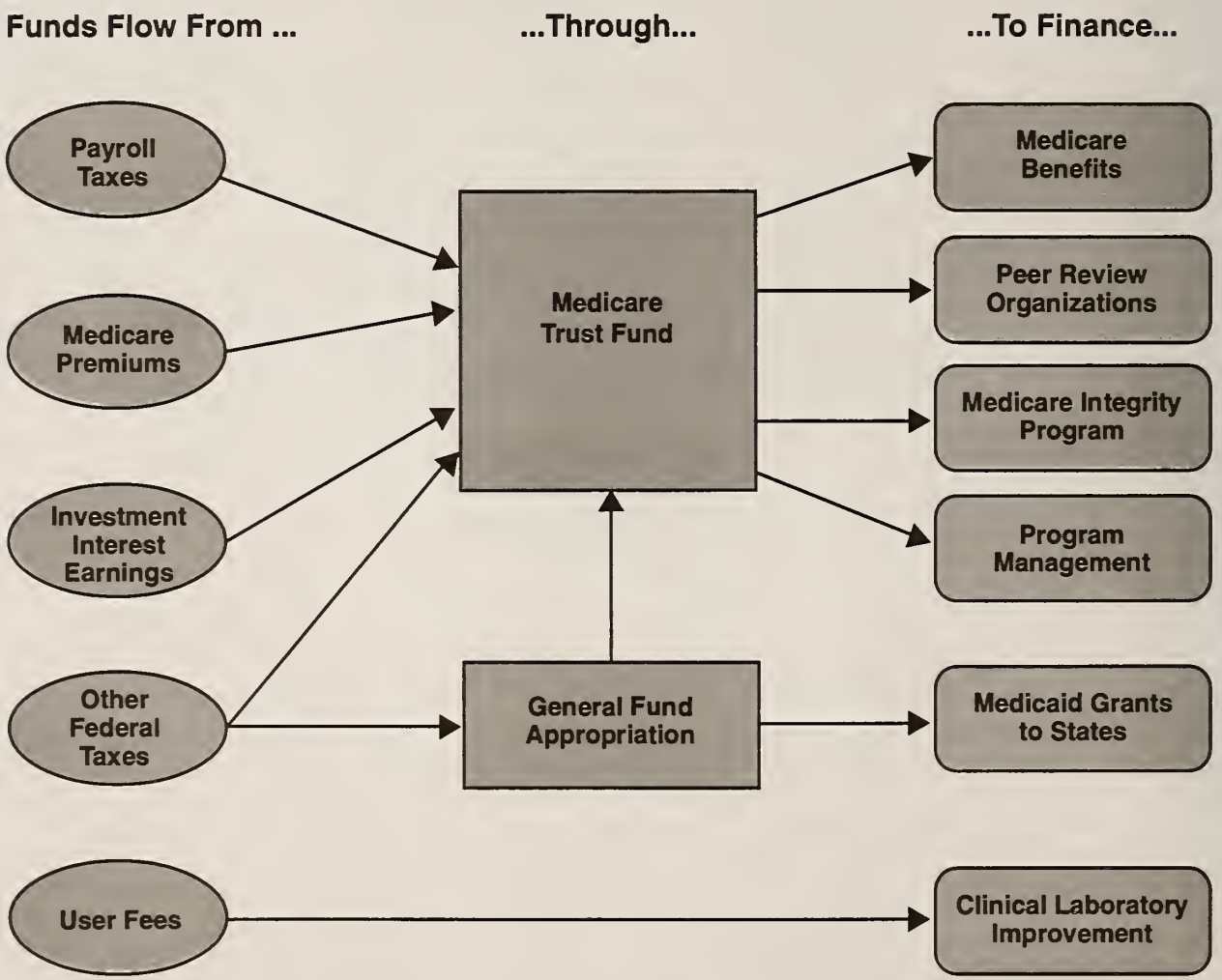


➤ HCFA is the largest purchaser of health care in the world. Medicare and Medicaid outlays represented 33.9 cents of every dollar spent on health care in the United States--47.7 cents of every dollar received by U.S. hospitals and 28.5 cents of every dollar received by physicians. HCFA and the programs it administers outlayed $285 billion in fiscal year (FY) 1997, 17.8 percent of the total Federal outlays.

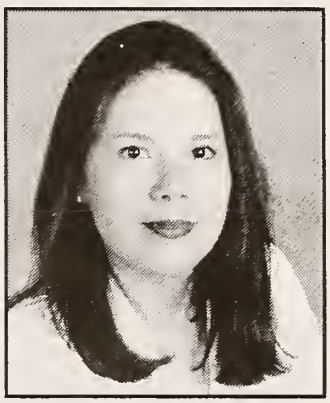
➤ Outlays for Medicare and Medicaid increased 7.1 percent from FY 1996 to FY 1997, compared to a 2.7 percent increase in the general cost of living as measured by the Consumer Price Index and a 2.9 percent increase in the CPI for medical goods and services.



FINANCING OF HCFA PROGRAMS & OPERATIONS



A Message from the Administrator



I am pleased to provide the Health Care Financing Administration's (HCFA's) annual report for fiscal year 1997. For more than three decades, Medicare and Medicaid have met the health care needs of elderly, disabled, and low-income Americans. Today, one in four Americans relies on these programs. Our objective is to work with the Congress, the States, our beneficiaries, and our provider partners to ensure that Medicare and Medicaid are strong and well managed.

The Balanced Budget Act of 1997 takes important first steps to reform Medicare, strengthen Medicaid, and establish a groundbreaking new children's health program. This Act made the most far-reaching changes to Medicare and Medicaid since they were created, and significantly advances our mission to serve as a prudent purchaser of health services on behalf of our beneficiaries.

The law changes many of our Medicare payment methodologies to make them more efficient and competitive, and less susceptible to abuse, and includes new tools to fight fraud and abuse across government agencies and to crack down on those who undermine HCFA's programs. Many of these new anti-fraud tools resulted from hard work and solid analysis by HCFA staff working with the Inspector General, the Department of Justice, and the Congress. These new tools build on the administration's success in the fight against fraud and abuse through such initiatives as Operation Restore Trust, and anti-fraud provisions in the Health Insurance Portability and Accountability Act of 1996. Now we can focus even better on our strategy of prevention, early detection, coordination with other government agencies, and enforcement against wrongdoers.

We have made considerable progress in financial reporting. In 1997, the second year HCFA was subject to a full scope audit, the financial statement received a qualified opinion compared to a disclaimer for 1996. We are moving in the right direction. Corrective action plans are in place and we are committed to resolving weaknesses identified in the audit process and reducing the payment error rate.

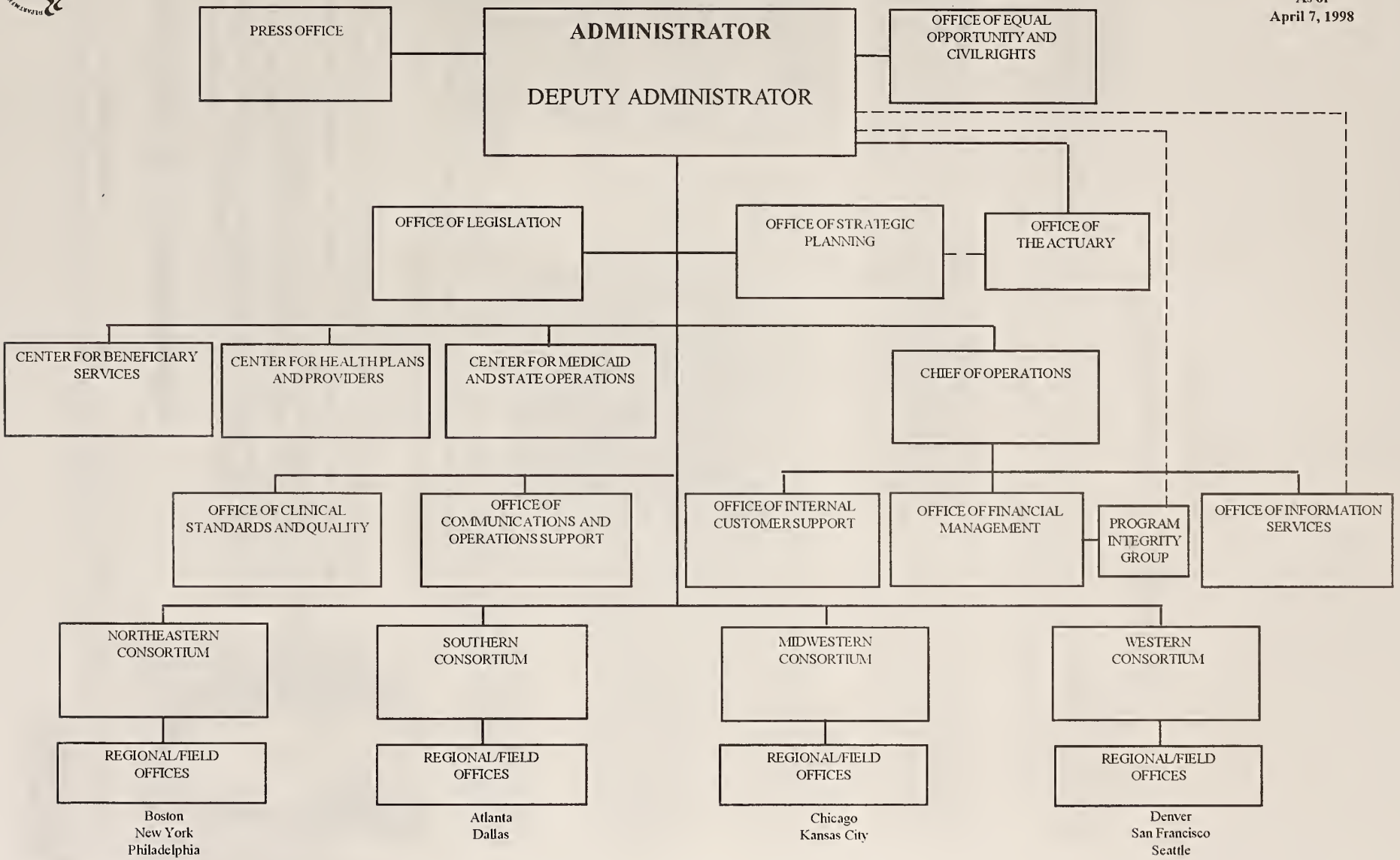
As we face the future and the work that lies ahead, I am proud of what HCFA is doing to meet those challenges. We have changed the way we do business to focus not on what works best for the agency, but what works best for the beneficiaries we serve. All of us at HCFA look forward to the challenge.

Nancy-Ann Min DeParle
April 1998

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED STRUCTURE

As of April 7, 1998



A Message from the Chief Financial Officer

As HCFA's Chief Financial Officer (CFO), I am pleased to present the financial statement report for fiscal year (FY) 1997. This is the annual report for HCFA and is meant to provide information useful to Congress, agency managers and partners, and the general public. HCFA, and the programs it administers, outlayed $285 billion in FY 1997, 17.8 percent of total federal outlays. Our financial statement shows that expenses, including payables, of $308.6 billion exceeded revenues of $306 billion. This is because the Medicare program expenditures, exceeded revenues, as they have since 1995. This is described in further detail in the Challenges and Supplementary sections of this report.

A description of the many functions and responsibilities of HCFA, including their scope and impact, is found in the Program Profile section. HCFA will implement performance measures in FY1999, and a description of our efforts to date is provided in the Performance Goals section. The Initiatives and Accomplishments section describes both the significant accomplishments of 1997 and the many initiatives underway. It begins with a description of the massive reorganization of HCFA that focuses our efforts on our three major audiences: beneficiaries, health plans and providers, and the States. The reorganization also concentrates program integrity and financial management functions under the CFO, and functions related to management information and systems development under a newly established Chief Information Officer.

HCFA has major initiatives underway to identify and meet beneficiary needs in terms of access, information, and quality of health care. Some initiatives focus on management of specific diseases like diabetes that can lead to serious medical complications and reduced quality of life. Others focus on the beneficiary's need for medical information to make informed choices on everything from insurance plans to preventive treatments. HCFA has made substantial progress in combating fraud, waste, and abuse, and the reforms enacted in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 provide significant new tools to further assist us. We are also working to continually modernize our systems to meet the needs of the new century, financial reporting requirements, and researchers who use the world's largest health databases. HCFA's expanded internet web site <http://www.hcfa.gov> offers data, statistics, publications (including our annual financial report), and other material for our beneficiaries, contractors, and the general public.

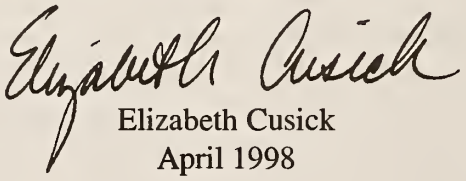
The Challenges section discusses major concerns of the agency including solvency of the trust funds, implementation of national health data standards, and claims payment accuracy. In 1997, two very disturbing pieces of information were brought to light in audits by the Office of the Inspector General (OIG). As part of the audit of the 1996 financial statement, we learned that roughly 14 percent of all Medicare claims submitted for payment by providers may not have been medically necessary. In a separate audit of home health agencies (HHA), OIG found that 40 percent of the total services included in 146 of 250 claims reviewed did not meet Medicare reimbursement requirements. Some portion of these errors may have been fraudulent. Although this information was received too late in fiscal year

1997 to make the corrective actions necessary to show progress on the 1997 financial statement, the unprecedented moratorium on the entry of any new HHAs into Medicare from September 1997 to January 1998 has had an impact. During the timeout, new anti-fraud mechanisms were put in place to keep unprepared and fly-by-night operations out of Medicare.

The Auditor's Opinion for FY 1997 shows that the claims error rate ranged from seven percent to sixteen percent, with an estimate point of eleven percent. Although some of this reduction may be due to efforts to educate providers on the importance of documentation, it is most likely that the reduction can be attributed to a concerted effort by OIG to obtain documentation on every claim. HCFA has developed a comprehensive corrective action plan (CAP) designed to further reduce the Medicare claims payment error rate. Measures are associated with each CAP item to track our progress and measure our successes. To date we have made significant headway in many areas.

During FY 1997, we implemented a CAP to address the largest dollar items that prevented an unqualified opinion for the FY 1996 financial statement. A revised methodology was used to estimate and validate the 1997 Medicare payables number. The Supplemental Medical Insurance premium withholding and transfer to the Part B Trust Fund was audited at the Social Security Administration with minimal reportable findings. We increased our efforts to work with the Medicare contractors and focus attention on their responsibilities related to financial reporting. We also reported two material weaknesses for 1997, (1) financial reporting for Medicare accounts receivable and other financial information, and (2) the lack of a process to measure the national error rate for Medicare claims payments.

The 1997 audit indicates that the auditors continue to have concerns about receivables reported by the Medicare contractors. Until a fully integrated accounting system is implemented at each contractor site, we anticipate extra efforts will be necessary to support accounts receivables and payables. The lack of a contractor-based accounting system also limits our ability to confidently implement the Debt Collection Improvement Act. We are committed to improving the reliability of data maintained by the Medicare contractors so that we can achieve our goal of receiving an unqualified, clean audit opinion for our FY 2000 financial statements.



Elizabeth Cusick
April 1998

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Overview

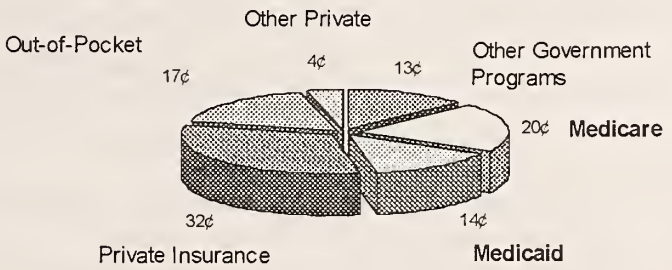
Chapter 1

PROGRAM PROFILE

The Health Care Financing Administration (HCFA), an operating division of the Department of Health and Human Services (HHS), is responsible for administering Medicare, Medicaid, and, beginning in 1998, the State Children's Health Insurance Program. In connection with the Departments of Labor and Treasury, HCFA (on behalf of HHS) is also responsible for implementing the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These provisions affect an estimated 160 million Americans.

HCFA is the largest purchaser of health care in the world. Medicare and Medicaid outlays, including State funding, represent 33.9 cents of every dollar spent on health care in the United States -- 59.2 cents of every dollar spent on nursing homes, 47.7 cents of every dollar received by U.S. hospitals, and 28.5 cents of every dollar spent on physician services.

The Nation's Health Care Dollar, CY 1996



Source:HCFA/OACT

HCFA and the programs it administers outlayed $285 billion in fiscal year (FY) 1997, 17.8 percent of total Federal outlays. In addition to establishing rules for eligibility and benefit payments, paying 853 million Medicare benefits claims, and providing States with matching funds for Medicaid benefits, HCFA carries out many other important activities:

- HCFA is responsible for safeguarding the fiscal integrity of the Medicare and Medicaid programs to ensure that appropriate, medically necessary benefit payments are paid correctly the first time, improper payments are recovered, and law enforcement agencies are assisted in the prosecution of fraudulent activities.

- HCFA is responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found.

- HCFA conducts an extensive program of research through payment grants and demonstrations aimed at improving the quality and affordability of health care, accessibility to care, and the efficiency of delivery and payment systems.

- HCFA is a leader in evidence-based decision making for coverage policy. The experience from our programs benefits the entire health care marketplace.

- HCFA maintains the Nation's largest collection of health care data and provides data and analytical services to the Congress, the Executive Branch, universities, and other private sector researchers.

To understand the HCFA financial story, you need to understand two key financial terms. **Expenses** are one of the ingredients of the financial statements that begin on page 49. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining annual income. Wherever possible, expenses are the basis for discussions of HCFA's financial activity. **Outlays** refer to the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. Outlays are used in the discussions of HCFA's financial activity only when comparable expense data are not available.

- HCFA maintains an enterprise security program that assures the confidentiality of personal and proprietary information concerning beneficiaries, providers, and fiscal agents respectively. Legal constraints include the Privacy Act.

- HCFA is working to develop national uniform standards for the electronic transmission of certain health information that is required by HIPAA.

- HCFA provides managed care choices to its beneficiaries and assures that managed care organizations meet quality, benefit, and financial integrity standards.

- HCFA oversees State regulation of private Medigap insurance to ensure that Medicare beneficiaries are afforded important consumer protections.

- HCFA is responsible for working with the States to implement health insurance reform provisions of HIPAA that will improve access to the group and individual health insurance markets for certain eligible individuals who move from job to job, or who lose their group health insurance coverage and must purchase coverage in the individual insurance market.

- HCFA's role is to protect, serve, and advocate for beneficiaries.

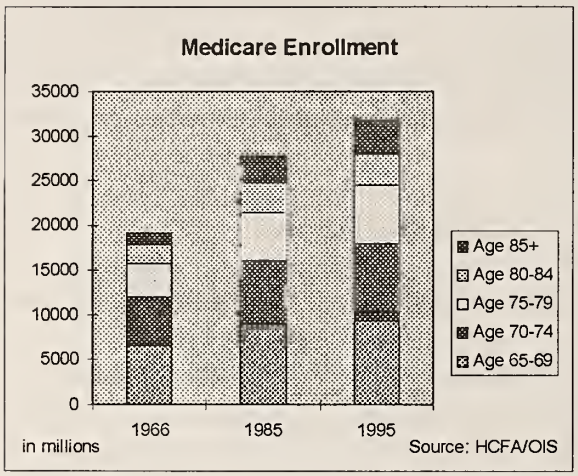
- HCFA is partnering with communities to foster improvement of entire health system.

In 1997, HCFA's expenses total $309 billion. Administrative expenses of $3 billion are less than one percent of the total. HCFA has approximately 4,000 Federal employees, but carries out many important operational activities through third parties: (1) 22,000 employees at 65 Medicare contractors have primary responsibility for processing Medicare claims, providing technical assistance to providers and servicing beneficiaries needs, including responding to inquiries; (2) 34,000 State employees have primary responsibility for administering Medicaid; (3) 6,000 State employees have primary responsibility for inspecting hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and (4) 1,600 employees at 53 Peer Review Organizations conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries. The Social Security Administration (SSA), the Railroad Board, and other Federal agencies also provide thousands of other staff, either full or part time, who support Medicare and/or Medicaid operations.

Of HCFA's 4,000 Federal employees, about 1,380 work in 10 regional offices around the country providing direct services to Medicare contractors, State agencies, providers, beneficiaries, and the general public. Approximately 2,620 of HCFA's employees work in Baltimore and Washington, D.C., providing funds to Medicare contractors; writing policies and regulations; developing more efficient operating systems; setting payment rates; managing programs to fight fraud, waste, and abuse; monitoring contractor performance; developing and implementing customer service improvements; and assisting States and Territories with Medicaid and other issues.

MEDICARE

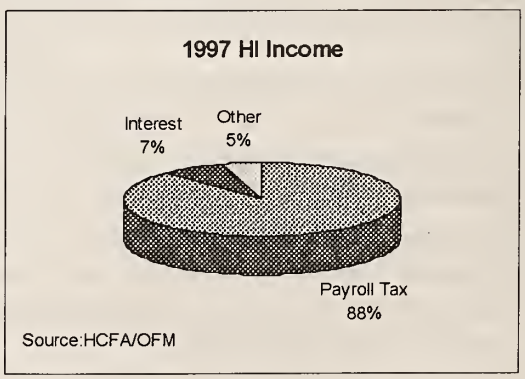
Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people aged 65 and over. In 1972, the program was broadened to cover the disabled, people with end-stage renal disease, and certain others who elect to purchase Medicare coverage.



Medicare is a combination of two programs, each with its own enrollment, coverage, and financing--Hospital Insurance and Supplementary Medical Insurance. The Balanced Budget Act of 1997 (BBA) created a third program called Medicare+Choice that restructures the Medicare managed care program and, through user fees, provides funding for better consumer information. Since 1967, Medicare enrollment has increased from 19.5 million to 38.6 million beneficiaries, a 98 percent increase. The percentage of beneficiaries aged 85 and over has grown from 6.2 percent in 1966 to 11.6 percent in 1995.

Hospital Insurance

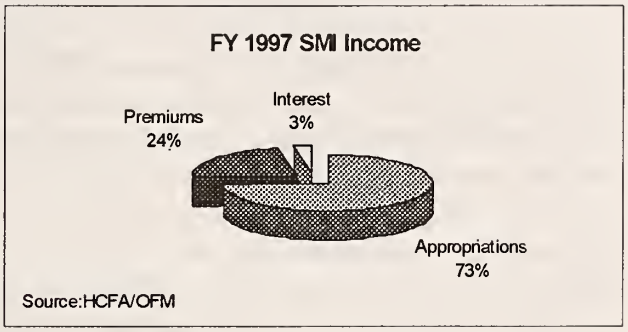
Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays participating hospitals, skilled nursing facilities, home health agencies, and hospice providers for covered services rendered to Part A enrollees.



Part A is financed through the HI Trust Fund, whose revenues come primarily through Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). In 1997, the Medicare payroll tax rate was 2.9 percent of annual wages--employees and employers were each required to contribute 1.45 percent of employees' wages, with no limitation, to the HI Trust Fund. The self-employed paid the full 2.9 percent. In 1997, income from payroll taxes was $112.7 billion, interest was $9.6 billion, and all other income was $5.9 billion. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Income not currently needed to pay benefits and related expenses is held in the HI Trust Fund, and invested in U.S. Treasury securities. The HI program expenditures began to exceed annual income in calendar year 1995. The 1998 Trustees Report of the Hospital Insurance Trust Fund projects the depletion of the fund by 2008.

Supplementary Medical Insurance

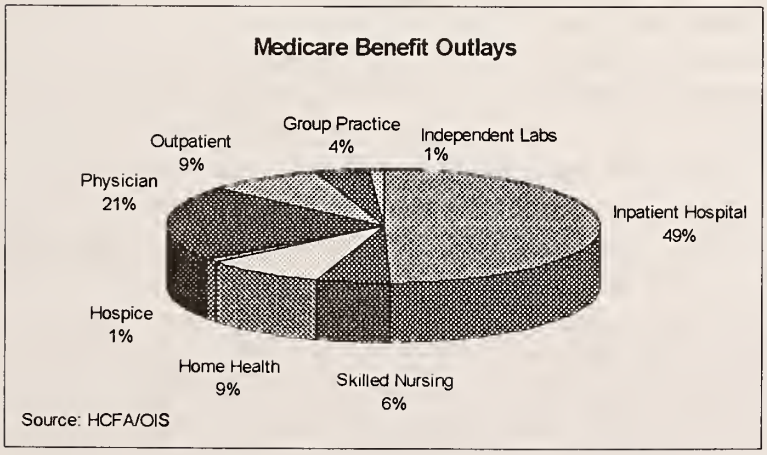
Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over and disabled people entitled to Part A. SMI covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by HI. The SMI coverage is optional and subject to monthly premium payments by beneficiaries. About 95 percent of HI enrollees elect to enroll in SMI.



The SMI program is financed primarily by a general fund appropriation (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries. The 1997 SMI premium, set by statute, was $43.80 per month. In FY 1997, beneficiary premiums accounted for $19.1 billion or 24 percent of SMI revenues. The remainder, $59.6 billion, came from the general fund appropriation, and $2.3 billion was from interest.

Medicare Benefit Payments

Medicare benefit payments accounted for a total of $207 billion in expenses. HI and SMI benefit expenses, including payables, were $136.1 billion and $71.3 billion respectively.



Inpatient hospital services now account for about 65 percent of HI benefit outlays. Hospital payment growth was driven by both increased hospital admissions and higher costs per admission. Spending for skilled nursing facility care and home health care continued to rise, but these services constitute a much smaller portion of total HI outlays.

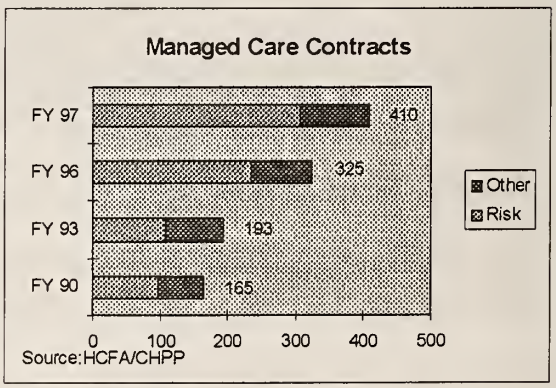
Inpatient hospital spending accounted for almost 30 percent of the increase in HI benefits outlays. Home health spending comprised 12.9 percent of total HI spending (8.5 of total Medicare spending) and 7.5 percent of the increase during FY 1997. It should be noted that the BBA re-allocated the majority of HHA spending to Part B.

SMI benefit outlays grew at 5.9 percent. Physician services, the largest component of SMI spending, grew 2.7 percent and accounted for more than 28 percent of the increase in FY 1997 SMI benefits. Though only constituting 14 percent of SMI benefits, payments for outpatient services accounted for nearly 57 percent of FY 1997 SMI growth.

HI benefit outlays per enrollee rose 7.0 percent to $3,944. However, fewer than 22 percent of HI enrollees received benefits in FY 1997--thus, spending per enrollee receiving services was much higher: $16,623. SMI benefit outlays per enrollee increased 4.4 percent to $1,982. Spending per enrollee receiving services was $2,234.

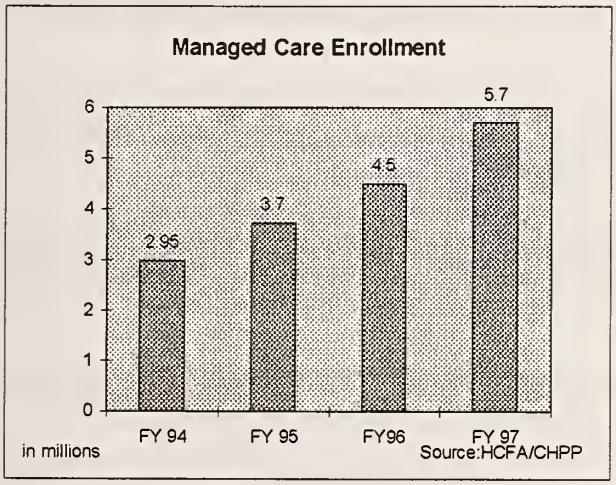
Managed Care

Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional fee-for-service arrangements. In general, a managed care organization consists of its own providers or a network of health care providers (physicians, hospitals, skilled nursing facilities, etc.) that agree to arrange for health care services for its members. The number of Medicare contracts with managed care organizations increased from 165 in FY 1990 to 410 contracts in FY 1997.



The BBA created a third Medicare program called Medicare+Choice, sometimes referred to as Medicare Part C, that will greatly increase the number of entity types that may participate in the Medicare managed care program. This program will go into effect in January 1999. The BBA makes it attractive for the new entity types to provide managed care choices to beneficiaries in geographic areas, such as rural and other underserved areas of the country, that have previously been without managed care options. The BBA also restructures the capitation rates for Medicare managed care and provides for a user fee to fund a consumer information campaign to provide beneficiaries with comparative plan information beginning in 1998.

Managed care plans currently serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans (HCPPs), and certain demonstration projects. Risk plans are paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare-covered services. Most plans offer additional services such as prescription drugs and eyeglasses. Cost plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not provide the additional services that some risk plans offer. HCPPs are paid in a manner similar to cost plans but generally cover only Part B Medicare services. Cost based plans and HCPPs, with certain limited exceptions, will be phased out under the BBA provisions. Any Medicare beneficiary may join a managed care organization if one is available in their area. Medicare beneficiaries can enroll or disenroll in a managed care plan at any time and for any reason with only 30 days notice.



Since 1994, there has been steady growth in the number of Medicare beneficiaries enrolled in managed care plans. In September 1997, approximately 5.7 million Medicare beneficiaries, or 14.7 percent of the total Medicare population, were enrolled in a managed care plan.

Managed care expenses accounted for $25.7 billion of the total $207 billion in Medicare benefit payment expenses in FY 1997. The growth of Medicare managed care creates new challenges for HCFA, particularly in the areas of quality assurance and beneficiary protections.

MEDICAID

Medicaid is the means-tested health care program for low-income Americans, administered by HCFA in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, however, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental

disabilities requiring long term care. The average annual enrollment for Medicaid was 33.1 million in 1997. Approximately six million people are dually entitled, that is, covered by both Medicare and Medicaid.

Under Medicaid's division of responsibilities, HCFA provides matching payment grants to States and Territories.

- State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1997, the Federal matching rate among the States ranged from 50 to 77 percent, with a national average of 57 percent.

- Federal matching rates for various State and local administrative costs are set by statute, and in 1997 averaged 56 percent.

Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to States.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include:

- Providing coverage to persons receiving Supplemental Security Income (disabled and elderly population), low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and

- Covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning, nursing facility services, and health screening for children under age 21.

State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States. For example, 27 State Medicaid programs cover psychological services, 49 cover adult dental services, and seven cover services of medical social workers.

Medicaid helps reduce infant mortality and improve maternal and infant health by bringing more eligible pregnant women into pre-natal health care and more infants into early health

supervision. States can pursue these goals by expanding eligibility, streamlining eligibility processes, conducting outreach, improving provider recruitment and retention, and adding new service delivery options or enhancements.

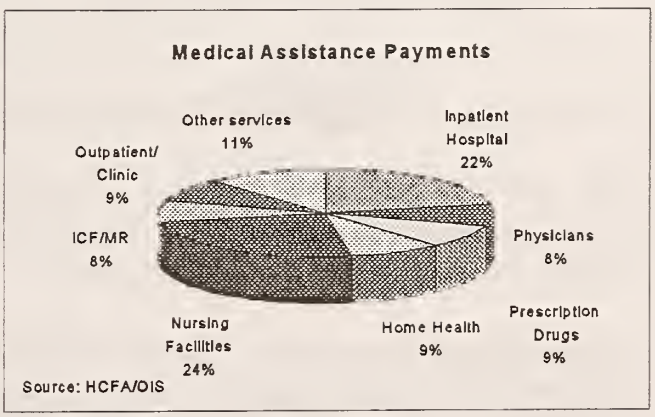
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a preventive and comprehensive health program for Medicaid-eligible individuals under the age of 21. It creates a framework under which Medicaid-eligible children can receive regular preventive health screenings and a range of follow-up services that may be broader than those available to Medicaid-eligible adults.

Medicaid is the largest single source of payment for health care services for persons with AIDS. Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of over 90 percent of the children and infants with AIDS. Total Medicaid spending for AIDS care and treatment in FY 1997 is about $3.3 billion. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

Medicaid, through its home and community-based services waiver program, provides long term care services, to hundreds of thousands of people, including the aged, disabled, technology dependent, children with particular rare diseases, persons with AIDS and respirator dependent children, in noninstitutional settings who would otherwise require costly institutional care such as provided by a nursing facility, hospital or intermediate care facility for the mentally retarded.

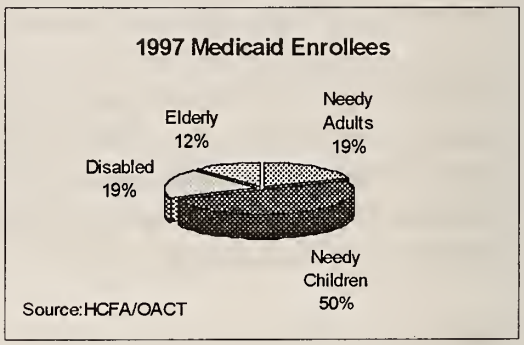
Payments

Under Medicaid, State payments for both medical assistance (MA) and administrative (ADM) costs are matched with Federal funds. In FY 1997, State and Federal ADM outlays were $7.6 billion--only 4.5 percent of the total Medicaid outlays. State and Federal MA outlays were $161.2 billion, or 95.5 percent of total Medicaid outlays, an increase of 4 percent over FY 1996. HCFA's Medicaid expenses totaled $96.7 billion.



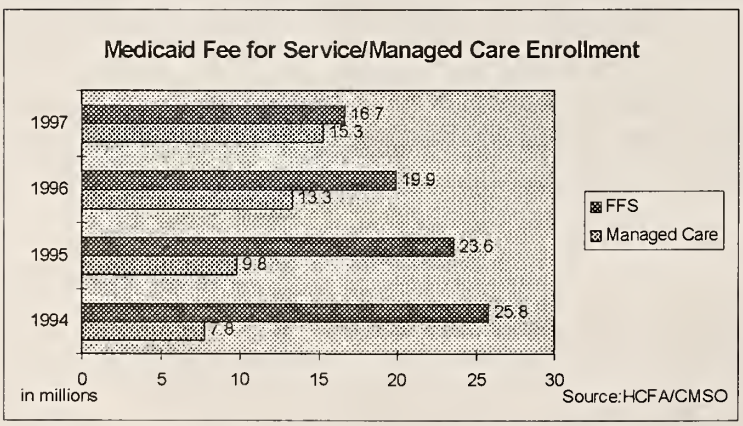
Enrollees

An estimated 36.2 million Medicaid beneficiaries received services in 1997. Children comprise 50 percent of Medicaid enrollees receiving services, but account for only 16 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 31 percent of Medicaid enrollees receiving services, but accounted for 64 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.



Managed Care

Many States are pursuing managed care as an alternative to the fee-for-service (FFS) system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of these waivers to introduce managed care plans tailored to their State and local needs, and there are currently 48 States offering a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 5 percent in 1993 to more than 48 percent by September 30, 1997.



HCFA and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Medicaid law provides for two kinds of waivers of existing Federal statutes to allow for the implementation of managed care.

1) State health reform waivers - Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects, and

2) Freedom of choice waivers - Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow States to develop innovative managed health care delivery or reimbursement systems.

State Children's Health Insurance Program

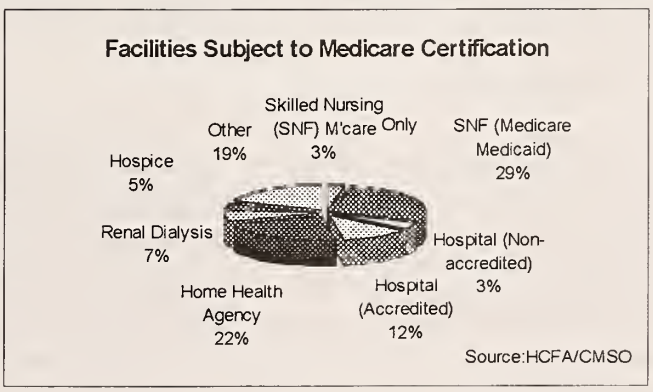
One of the major provisions of BBA is a major new health insurance program for children. Implemented as Title XXI of the Social Security Act, this program was created in response to a pressing social need. Title XXI will provide health insurance, preventive health care, and other important health services to children in need through State-based programs developed cooperatively by the States and Federal government. The new State Children's Health Insurance Program is an important step forward in meeting the health needs of the nation's children and an important new responsibility for HCFA.

OTHER HCFA ACTIVITIES

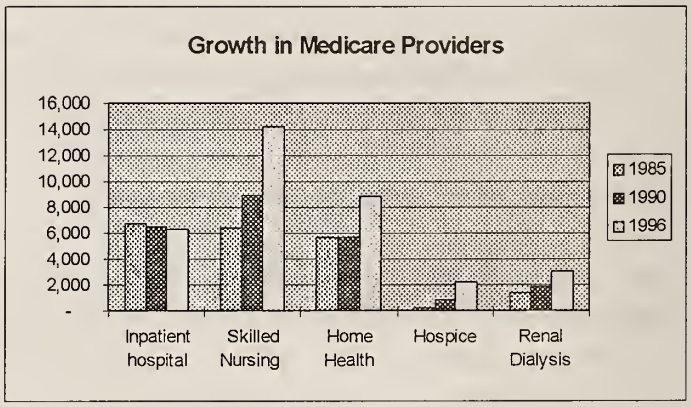
In addition to making health care payments on behalf of our beneficiaries, HCFA makes other important contributions to the delivery of health care in the United States.

Survey and Certification Program

The Survey and Certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. In FY 1997, State surveyors conducted 43,579 inspections and cited 23,265 facilities for deficiencies. Over 59,000 facilities are certified.



There has been an overwhelming growth in providers with the largest increases in skilled nursing facilities, home health agencies, hospices, and end stage renal dialysis (ESRD) facilities.



Quality of Care

Through Peer Review Organizations, ESRD Networks, State Agencies, and others, HCFA collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both FFS and managed care settings. These collaborative projects often employ a sequential process that includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality indicators and the publication of performance information.

HCFA has been a leader in the development of quality indicators. Our goal is to collect measures that will help to improve the health status of our beneficiaries or help them make informed choices about their health care. Additionally, these quality indicators will assist health care providers in monitoring the care they deliver. This is an area in which we have worked very closely with the private sector, consumers, and providers to develop new tools.

Coverage Policy

In today's health care market, every insurer and health care purchaser must deal with coverage policy. Private as well as public insurers, like Medicare, want to purchase high quality health care for the best price. Health plans, whether public or private, managed care or traditional indemnity plans, must control costs while still continuing to assure the highest quality of care for their subscribers. This cannot be done without authoritative evidence of the value of each individual service. These concerns have led Medicare to pay for a growing list of preventive services.

Medicare is a leader in **evidence-based decision making** for coverage policy. We rely on state-of-the-art technology assessment and support from other federal agencies, as well as the advice of the medical community and private sector studies. Our own extensive reimbursement data contain additional useful information that is used by the Agency for

Health Care Policy and Research (AHCPR) and others for assessing the effectiveness of a variety of medical treatments. The sheer numbers of beneficiaries that we serve and the wealth of information that we possess about them makes Medicare an important force in the market.

Insurance Oversight

HCFA has primary responsibility for setting standards for the **Medigap** insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. HCFA works with State insurance counseling offices to ensure that suspected violations of the laws governing the marketing and sales of Medigap are addressed.

HCFA is also responsible for implementing the data standards provision of HIPAA. The Administrative Simplification provision is aimed at reducing administrative costs and burdens in the health care industry. It requires the HHS to adopt **national uniform standards** for the electronic transmission of certain health information. HCFA is working with both public and private organizations to develop the best standards possible. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any electronic transmission of specified transactions.

As a result of the **insurance reform provisions** of HIPAA, HCFA has assumed a new role in relationship to State regulation of health insurance and health coverage. HCFA is working with the States to implement the provisions that will improve access to the group and individual health insurance markets for certain individuals. These new consumer protections affect an estimated 160 million individuals. These Federal statutory provisions became effective as of July 1, 1997. We have been working closely with the States and the National Association of Insurance Commissioners (NAIC), as well as other State groups, to get their views and comments on the policy issues and regulatory processes. The expectations were that States would implement/enforce the legislation. To date five States -- California, Missouri, Rhode Island, Massachusetts, and Michigan -- have not passed conforming legislation, thus requiring HCFA to assume enforcement responsibility. Other States have opted not to implement some aspect of the insurance reform, thus requiring the Federal government to assume a more active role. These unanticipated roles have stretched HCFA's resources.

OUR MISSION, VISION, AND GOALS

MISSION

We assure health care security for beneficiaries. Health care security means access to affordable and quality health care services, protection of the rights and dignity of beneficiaries, and provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

VISION

We guarantee equal access to the best health care. This vision reflects our commitment that all individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income, or other circumstances, and the quality of health care they receive is the best that can be provided.

GOALS

- Protect and improve beneficiary health and satisfaction
- Purchase the best value health care for beneficiaries
- Promote beneficiary and public understanding of HCFA and its programs
- Promote fiscal integrity of HCFA's programs
- Provide leadership in the broader public interest to improve health
- Foster excellence in the design and administration of HCFA's programs

Performance Goals

The Health Care Financing Administration (HCFA) developed and implemented a comprehensive strategic plan in February 1994. Its six goals, updated in 1997, reflect the mission and vision of the agency and provide a framework for moving toward the future. With the dual responsibilities of serving the Medicare and Medicaid beneficiaries while also protecting taxpayer dollars, HCFA is repositioning itself to become a more effective purchaser of health care services. This new focus is essential because of the increasing cost of health care, shrinking resources, and changing public attitudes.

Two legislative provisions have influenced the development of performance goals to track progress toward meeting these goals. The Government Performance and Results Act of 1993 (GPRA) requires Federal agencies to define their mission and align their activities and resources to support mission-related outcomes. GPRA requires agencies to measure their performance against program-driven criteria to ensure that they are meeting agency goals. The Clinger-Cohen Act, also known as the Information Technology Management and Reform Act (ITMRA), requires federal agencies to use information technology (IT) to improve mission performance and service to the public and to strengthen the quality of government IT decision-making by measuring performance. It also establishes the position of the Chief Information Officer (CIO). The 1997 reorganization of HCFA aligns our major activities organizationally, creates a CIO, and will enhance our abilities to focus on improving the quality of beneficiaries' health care and safeguarding the fiscal integrity of the Medicare and Medicaid programs.

In 1997 HCFA submitted its first annual performance plan as part of the FY 1999 budget submission, as required under GPRA. The plan includes 22 performance goals that are representative of a full range of HCFA activities from program benefits to internal administrative functions. Both baseline (where applicable) and target levels of performance are specified. The plan also links the 22 goals to HCFA's major business functions (as defined in the budget) and to both the HCFA and HHS strategic plans. HCFA will be required to report on performance under this plan in March of 2000.

HCFA's performance measurement philosophy is based on two principles: (1) the most important things to measure relate to ensuring that Medicare and Medicaid beneficiaries receive the highest quality of health care, and (2) our goals must be representative of program performance. In addition, our measurement approach is shaped by the nature of the Medicare and Medicaid programs, namely, HCFA employees are only a small portion of the large complex network that makes Medicare and Medicaid work successfully, and the Medicare and Medicaid benefit payments are largely driven by external factors.

HCFA's goals fall into three categories. The "core" goals are those most directly associated with beneficiaries, including access to and satisfaction with, health care and content of care received. Goals that are most closely aligned with beneficiaries, and thus are more outcome oriented, are at the core of the Agency's approach to performance measurement. HCFA will rely on goals, such as reducing use of restraints in nursing homes, where there is clinical consensus that the measure is a significant indicator of performance on content of care. These goals will change as clinical consensus. The goals will also need to change based on interventions HCFA is undertaking and as results of clinical studies are published.

The second level of measurement consists of goals that are closely related to beneficiaries and in some cases are considered proxies for the core beneficiary-centered goals. Because of the connection to beneficiaries, the goals at this level are important indicators of program performance. For example, measurement of beneficiaries' receipt of influenza vaccines and mammograms are not only direct measures of HCFA quality efforts, but also are considered supplemental proxy measures of beneficiary access to care. Other goals in this category connect to specific administrative activities but are also related to core goals of access and satisfaction, for example, increasing plan choices and routinely providing explanatory information on Medicare benefits.

The third level of goals rounds out HCFA's approach by incorporating goals (generally output measures) that are more closely aligned with administrative functions. Examples of measures in this third level relate to improvements in payment safeguard strategies and claims processing. Information/data on specific workload functions (e.g., number of facilities surveyed and cost per claim) are included in the budget justification.

This tri-level approach to GPRA performance measurement provides comprehensive coverage, using a balancing among types of measures connecting to the Agency business activities. HCFA believes it is important to articulate and measure goals at each of these three levels. In so doing, HCFA has focused on identifying a set of significant meaningful performance measures that speak to both fundamental program purposes, but also incorporate key output-oriented measures that tie to administrative activities.

On a parallel track, the IT Investment Review Process is designed to ensure that all IT investments support specific agency strategic business objectives before funding is approved and that performance measures are developed that relate to specific goals and objectives listed in the HCFA strategic plan.

Initiatives/Accomplishments

While health care expenditures have been increasing at rapid rates, HCFA's administrative costs have actually declined after taking inflation into account. The aging of the population has resulted not only in an increase in program enrollment but also increased use of medical services and, thus, more claims for payment. Increasing numbers of disabled beneficiaries, and a proliferation of providers, such as managed care plans and home health agencies, have all put tremendous pressures on HCFA's administrative costs, in a budget environment in which administrative spending has been virtually level since FY 1993.

Both 1996 and 1997 were key legislative years with the passage of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** and the **Balanced Budget Act of 1997 (BBA)**. The impact of these two laws is dramatic. Implementation of these laws, the rapidly changing health care industry, and a need to ensure we have an effective two-way communication strategy with our primary customer, the beneficiaries, have driven much of the activity during FY 1997 and into the future. We plan to implement the most important legislative provisions on schedule, and have advised interested parties that other provisions may be delayed. This is due in part to the diversion of programming resources to ensure that millennium changes to accommodate the year 2000 are completed. In addition, some changes fall in areas within HCFA where there are a limited number of analysts skilled in the specific topic, and the implementing regulations must be handled sequentially. There are also increasing stresses on the regional offices due to growing responsibilities in HCFA related to fraud and abuse, the children's health program, insurance reform and managed care expansions.

HCFA'S REORGANIZATION

In 1997, HCFA began a reorganization designed to enhance our beneficiary-centered focus. The reorganization will enable HCFA to respond more efficiently to rapid changes occurring in health care so that we can better serve our beneficiaries. Three separate HCFA centers were established to focus on our three primary audiences, our beneficiaries, the health care plans and providers who care for beneficiaries, and the States who partner with us in serving our Medicaid beneficiaries. This customer model is similar to markets in the private sector. It recognizes that driving forces behind current changes in the nation's health care system are not internal to the agency, but external. For example, just as in the commercial health care system, managed care is emerging as an integral and rapidly growing part of our operations. Therefore, it makes sense to integrate Medicare managed care and fee-for-service operations throughout the agency into a Center for Health Plans and Providers, rather than maintaining a separate Office of Managed Care, for example.

HCFA's new organizational structure reflects the importance we place on our relationship with States and our commitment to the implementation of HIPAA requirements. Under the new structure, one of the three operational centers, the Center for Medicaid and State Operations, will deal solely with State issues including the Children's Health Insurance Program (CHIP). Within this center, there is a special team, the Program Executive for Insurance Standards that is responsible for implementation and enforcement of the insurance reform provisions of HIPAA.

HCFA's new organizational structure focuses on the beneficiary as HCFA's ultimate customer by establishing, for the first time, a component dedicated explicitly to understanding and meeting the needs of beneficiaries. The Center for Beneficiary Services (CBS) will exist to protect, serve, and to be an advocate for beneficiaries. It is designed as the focal point for all of the agency's interactions with beneficiaries, their families, care-givers, and other representatives of beneficiaries. The CBS will provide information to help beneficiaries and concerned parties make informed decisions about their health care and program benefits administered by HCFA. It will assess beneficiary and consumer needs, design and implement beneficiary services' initiatives, and develop performance and evaluation programs for beneficiary services activities. The CBS will develop national Medicare policies and procedures for eligibility, enrollment, entitlement, coordination of benefits, managed care enrollment and disenrollment, and appeals. New methods to improve health care delivery systems from the perspective of our beneficiaries will be developed and tested through demonstrations and interventions. Contracts and grants involving Medicare customer service will be handled by the CBS, and it will coordinate the activities of Medicare's contractors.

Functions related to HCFA's business operations are governed by the Chief of Operations (CoO). Within CoO, financial management and program integrity functions were consolidated under the Chief Financial Officer in the Office of Financial Management, and functions related to systems and management information were consolidated under the Chief Information Officer in the Office of Information Systems. A Financial Management and Investment Board (FMIB) with representatives from all components was established to develop recommendations for Executive Council decision-making on HCFA's financial operating plan and information technology (IT) investments beginning with fiscal year 1998. The CoO is also responsible for HCFA's human resource needs as well as contracting and administrative management functions.

The Office of Clinical Standards and Quality, another major office, focuses on quality and coverage issues, which are discussed in detail below. HCFA's accomplishments during FY 1997 have been grouped according to the six goals.

Goal 1 - Protect and Improve Beneficiary Health and Satisfaction

HCFA has defined "quality of care" as the "extent to which health care and health-related services result in desired outcomes and greater satisfaction with care for the populations and individuals we serve." This definition of quality of care and the mission statement serves as the agency's foundation for developing an integrated quality program framework.

Prevention

With the passage of the BBA, Medicare will pay for part or all the cost for routine screenings for breast, cervical, vaginal, and colorectal cancers. Benefits for bone-mass testing begin July 1, 1998, and prostate cancer screenings start in 2000. In addition, new benefits for diabetics are aimed at encouraging all diabetics to self-monitor their blood glucose levels more frequently by paying for monitoring equipment and testing strips.

State Children's Health Insurance (CHIP)

HCFA is working to ensure that CHIP is integrated with Medicaid and other state child health programs and reaches eligible children with the right balance of Federal standards and State flexibility. Beginning in FY 1998, the new law will invest $47 billion in federal funds over 10 years for CHIP. The purpose is to enable States to initiate and expand child health assistance to uninsured, low-income children. Such assistance should be provided primarily through either or both of two methods: (1) a program to obtain health insurance coverage that meets requirements in Section 2103 of the BBA relating to the amount, duration, and scope of benefits; or (2) expanding eligibility for children under the State's Medicaid program. In order to be eligible for funds, States must obtain approval from HCFA for a State Child Health Plan. The first option is a capped entitlement and all funding stops when the State reaches its allocation.

It is the charge of HCFA to guide the States through the various stages of implementing CHIP to insure State Plan approval in a timely manner so that Federal funds are made available to the States to care for the Nation's most vulnerable population. HCFA provided the States a procedure for plan submittal, developed financial reporting forms and claims procedures, coordinated with Medicaid expansions for children's health, and developed procedures for annual reports, evaluations, and studies. The States have been advised of their allotments for Federal fiscal year 1998.

Defining Beneficiary Needs

The Medicare Current Beneficiary Survey (MCBS) helps HCFA ensure that its programs and services respond to the health care needs of our beneficiaries in a number of ways. The only comprehensive source of information on the health, health care, socioeconomic, and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries; the MCBS helps HCFA in monitoring and evaluating the health care needs of Medicare beneficiaries. The MCBS directly involves beneficiaries in defining their health care needs by interviewing a large representative sample of them about their health status and physical functioning, access to care, and satisfaction with the Medicare services they use. MCBS also aids in HCFA's educational and outreach initiatives by collecting information on which methods are best suited to reaching specific subgroups of the Medicare population, and what the communication preferences are for the general Medicare population and several specific subgroups.

Research studies are also used to determine how beneficiaries are affected by certain factors For example, in 1997 a study completed by HCFA concluded that race and income have substantial effects on mortality and use of services among Medicare beneficiaries. Medicare coverage alone is not sufficient to promote effective patterns of use by all beneficiaries. This study linked 1990 census data with Medicare administrative data. The MCBS also was used to validate the results and determine rates of immunization against influenza. These results have helped inform the health care community that socioeconomic status influences the use of services and focus policy discussions on ways to measure and improve access to care for population subgroups.

HCFA is conducting market research and has completed the inventory work of documenting what is known about beneficiary information needs and communication preferences for the general Medicare population and several specific subgroups. The majority of focus groups have been completed for these same populations and the MCBS data were gathered during the spring of the year. Draft reports of results from these activities are becoming available and we have begun to distribute the findings to the Agency. We have also received reports of findings from work with providers and other partners.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing telephone survey of adults, concerning their health status, practices, and behaviors, and has an overall purpose of improving chronic disease control in the elderly. It operates as a partnership between the Centers for Disease Control and Prevention (CDC) and the individual state health

departments. Use of the BRFSS at HCFA will assist in the assessment of beneficiary health status and trends in care, as well as the examination of beneficiary health care needs. These data are being used to assist in the planning and monitoring of health care quality improvement initiatives at HCFA.

Goal 2 - Purchase the Best Value Health Care for Beneficiaries

HCFA is the largest purchaser of health care in the United States, and is transitioning from a payer organization to a "prudent purchaser of health care services." This transition is being made through collaboration with a number of large purchasers to explore opportunities for obtaining the best value in quality, cost-effective health care services for our beneficiaries. To that end, we have created an external customer profile -- a new, user-friendly system that will enable HCFA to deal with our provider groups and advocacy communities and will enhance coordination of customer correspondence, report gathering and research.

Along with other large purchasers of health care, we are developing purchasing strategies that will help us not only meet our goal of providing high quality health care to both Medicare and Medicaid beneficiaries, but also provide the best value in services for the dollars we spend. This is vital in view of the current funding situation.

Managed Care

It has long been a credo of Medicare that beneficiaries should have a wide range of choices to meet their health care needs, whether through managed care or fee-for-service. The BBA contains the most sweeping changes for Medicare managed care since the program's inception. Beginning in 1999, the new "Medicare + Choice" program allows additional entity types to participate in the Medicare managed care program and could greatly increase the number of Medicare managed care plans. In addition, the laws make it attractive for the new entity types to provide managed care choices to beneficiaries in geographic areas that have previously been without managed care options. HCFA estimates that one year of operation under the new statutes will raise the access for beneficiaries with at least one managed care plan in their area of residence (i.e., the plan's service area) from 70 percent to at least 80 percent. HCFA is particularly interested in the growth of managed care options in rural and other underserved areas of the country.

Medicare+Choice plan types under the BBA will include coordinated care plans (e.g., Health Maintenance Organizations and Competitive Medical Plans both of which were previously allowed to participate in Medicare, as well as Preferred Provider Organizations and Provider Sponsored Organizations), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts, for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

HEDIS® - In 1996, we worked with the National Committee for Quality Assurance (NCQA) to adopt a system of quality measures called HEDIS®, the Health Plan Employer Data and Information Set, to create outcome measures that could be adapted to Medicare and Medicaid. The result was HEDIS® 3.0. In 1997, we required more than 250 Medicare managed care risk and cost contractors to report measures from HEDIS® 3.0 to the NCQA. These measures were in effectiveness of care, use of services, access to care and other areas where we thought it important for HCFA as the largest purchaser of health care to have a better understanding of the performance of Medicare managed care plans.

We also contracted with the Island Peer Review Organization to conduct a validation of the effectiveness of care and frequency of selected procedures' measures. We are currently analyzing both the HEDIS® data submitted by the plans, and the results of the validation as we determine the best ways of using HEDIS® in improving quality of care and in providing consumers with information in choosing among plans. For Medicaid, the States have the option of using those HEDIS® measures that are most appropriate for their populations.

Healthy Aging - HCFA is in the early stages of developing a Healthy Aging initiative. The idea is to bring the best science to the health promotion field, and determine which programs and approaches work most effectively to promote healthy aging. To the extent that interventions can preserve functional status and forestall disability, beneficiaries will have reduced need for medical services. We are especially interested in those programs demonstrated to reduce risk factors, such as smoking, obesity, physical activity, nutrition, falls, and hypertension. HCFA is actively reaching out to other federal and non-federal organizations to share information. The goal of healthy aging is spelled out in HHS strategic objective 2.5, "Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience."

FACCT - HCFA is on the Board of Directors of the Foundation for Accountability (FACCT), a nonprofit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care based on quality. The Board includes a wide range of public and private sector purchasers, consumer groups, and organized labor. The goal of this nonprofit group is twofold: (1) to develop new outcome measures for value purchasing and health plan accountability; and (2) to develop consumer information strategies derived from measures for consumers, purchasers, and managed care plans. FACCT plans to provide education to help the public make informed decisions when choosing a health plan. HCFA is interested in FACCT's ability to integrate the perspectives of people who buy and use health care into quality of care measurement. FACCT endorsed three condition-specific outcome measures and a consumers' information strategy which

HCFA is interested in testing. The measures are diabetes, depression, and breast cancer. FACCT's consumer oriented perspective provides a necessary counterpoint to provider-oriented quality assurance organizations.

- **Diabetes Quality Improvement Project** - Persons with diabetes need regular screening tests to prevent and limit the many serious complications of the disease, ranging from vision and vascular problems to kidney disease. HCFA is sponsoring a coalition that includes NCQA, FACCT, the American College of Physicians, the American Academy of Family Physicians, the American Diabetes Association, the Department of Veteran's Affairs, and other groups. This coalition will jointly develop process and outcome measures for diabetes, producing a common set of national standards for diabetes care. This effort will result in enormous advantages to providers, plans, and other stakeholders by reducing the burden of data collection normally associated with multiple measures and providing a basis for comparability of care across settings.

- **Cooperative Cardiovascular Project (CCP)** - Heart failure and shock continue to lead the list of reasons for Medicare treatment. The CCP is a national project that addresses the quality of hospital care for Medicare patients with heart attacks. The CCP focuses on improving hospital performance in the areas of heart attack treatment or preventive measures such as thrombolytics (clot busters), aspirin, beta blockers, and smoking cessation. Peer Review Organizations (PROs) provide hospitals with individualized feedback on CCP performance measures (or quality indicators). Preliminary results have shown an improvement in all CCP quality indicators, a decrease in length of stay, and a 10 percent drop in mortality rates for heart attack patients. The PROs have created state-specific plans for follow-up samples and reinforcement of the improvement activities in 1997 and 1998. More detailed information and data charts are available at www.usccp.org.

- **Inpatient Peptic Ulcer Project** - HCFA is leading a multi-state quality improvement project to improve care for Medicare beneficiaries hospitalized with peptic ulcer disease and prevent ulcers from recurring. HCFA spends an average of $825 million each year for treating patients with peptic ulcer disease in the hospital setting. Untreated H. pylori results in recurrent ulcers, repeat hospitalizations, unnecessary surgical procedures and associated complications, mortality, chronic gastritis, and gastric cancer. The PROs have been working collaboratively with hospitals since December 1996 to improve treatment for patients with peptic ulcer disease. Baseline results reveal opportunities for improvement. Over the next 6 months, intervention data, outcome data, and follow-up results will be available.

End Stage Renal Disease (ESRD) Initiatives

As the single largest purchaser of ESRD treatment services in the United States, HCFA has a critical responsibility for the quality of care delivered to these patients. Our goal is to improve the quality and accessibility of the services, while keeping an eye on costs. We are building a comprehensive, integrated approach to the quality management process for ESRD on a number of fronts by implementing a new focused survey process, revising the Conditions for Coverage, enhancing the quality improvement projects of the ESRD networks, and improving the working relationships between Networks, State Agencies, and Peer Review Organizations with quality improvement as our goal. "It's Your Life . . . Know Your Number!" is an ESRD patient brochure designed to educate ESRD patients about their condition so they can determine if the hemodialysis treatments they receive are adequate.

Goal 3 - Promote Beneficiary and Public Understanding of HCFA and its Programs

The HCFA Home Page

HCFA's data bases are the largest and most complete source of health care information in the United States. In 1996, HCFA unveiled a new, expanded Internet web site <http://www.hcfa.gov> that offers data, statistics, publications (including our annual financial report), guidelines on detecting fraud, and other material for our beneficiaries, contractors, and the general public. Currently, the majority of beneficiaries do not have a direct link to Internet. However, beneficiary and consumer advocates, insurance counselors, and public entities who are the most frequent sources of beneficiary advice and counseling do possess this technology, and it will become an even better source for helping to disseminate this data. In April 1998, a new web site was made available: <www.Medicare.gov>. This site was designed specifically for beneficiaries with beneficiary input. We believe our beneficiaries will greatly benefit from this widely accessible and user-friendly data source.

Comparative Information

We wish to make comparative information available to all Medicare beneficiaries to assist them in making appropriate health care choices. Currently, Medicare Compare, the Managed Care Plans Comparison Database, is on the HCFA web sites listed above. Medicare Compare provides a wealth of information on managed care plans, allowing users to "comparison shop" for plans. Users can look up information in different areas, by state, county, or zip code. They can also compare costs for premiums and types of services offered. Within the next year, we will be adding a larger number of plans and more variables for comparison, such as quality measures and beneficiary satisfaction data.

Annual Publications

HCFA's Medicare Handbook, distributed to all newly enrolled beneficiaries, describes in a clear and concise way the most important features of the Medicare program. Additionally, HCFA and the NAIC publish yearly the "Guide to Health Insurance for People with Medicare." The guide provides a comprehensive description of what Medicare does and does not pay for, and an extensive discussion of the Medigap program to assist Medicare beneficiaries in making a knowledgeable analysis of supplemental insurance available to them, fostering their choice of coverage to meet their individual needs.

Health Promotion and Disease Prevention Through Vaccination

HCFA is striving to measurably improve the health status of beneficiaries, and to build capacity for improving health status through several programs that emphasize vaccination. The goal of the annual flu shot campaign is to achieve 60 percent flu immunization rate for Medicare beneficiaries by the year 2000. An exciting component of the campaign is the Horizons Pilot Project, which is designed to improve access to immunizations and ultimately improve the health status of African-American Medicare beneficiaries. HCFA partners with eight Peer Review Organizations and 12 Historically Black Colleges and Universities to design and implement a variety of statewide multifaceted interventions designed to increase flu immunization rates among the target group. Preliminary data from targeted intervention areas show increases in immunization rates up to 35 percent.

The Maryland Medicare Customer Service Center (MCSC)

The Maryland Medicare Customer Service Center opened for business in August 1997. This service center is a single source of Medicare information for Maryland Medicare beneficiaries. Although the majority of calls relate to claims issues, customer service representatives are able to handle all questions posed by the callers because over eight computer systems are available as resource databases. The MCSC has been initially designed to handle approximately 560,000 calls per year using state-of-the-art workstations, client server technology, specially designed customer service screens and computer telephone integration. The MCSC is designed to provide a wealth of Medicare general, fee-for-service and managed care information. Marketing of the MCSC included the printing of the new 800 number on selected Explanation of Medicare Benefit (EOMB) notices; radio and television spots; print media, including advertisements on the sides of buses; and information booths at Senior Fairs.

Medicare Summary Notice (MSN): In FY 1997, we began national implementation of the new and improved notice to beneficiaries when a claim is paid on their behalf. Among the many benefits of each new notice is a "Help Stop Fraud" message that is included to help beneficiaries review their notice for suspected fraud. These messages can be tailored to locality to inform beneficiaries of local fraud scams.

The MSN will replace multiple forms used today. MSNs will be produced on a monthly basis for claims filed with the intermediary and carrier. The new MSN is designed to enhance customer understanding, make it easy to file appeals, reduce paperwork, and present data in a clear, concise format.

Goal 4 - Promote Fiscal Integrity of HCFA Programs.

The passage of the HIPAA and the BBA has a tremendous impact on the fiscal integrity of HCFA's programs. Implementation of the provisions contained in these laws will provide continuing impetus toward sound financial management and the elimination of fraud, waste, and abuse in Medicare.

Status of the Trust Funds

The 1997 Report of the Hospital Insurance (HI) Board of Trustees projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2001. After adjusting for the effects of the BBA, the HI trust fund is projected to be depleted in 2010. The BBA also established a Bipartisan Commission on the Future of Medicare to develop long-term solutions to meet the challenges of the baby boom generation.

Program Integrity Activities

The Medicare contractors carry out a range of activities collectively known as "payment safeguards" to prevent, detect, and recover inappropriate Medicare benefit payments. Over the past several years, these payments have returned significant savings to the trust funds. Payment safeguards include:

- Medicare Secondary Payer (MSP)--activities that identify instances where an insurance company may be the primary payer, prior to payment of the claim by Medicare or as a recovery after payment by Medicare,

- Medical Review and Utilization Review (MR/UR)--activities that ensure medical services provided are covered by Medicare and are reasonable, necessary and appropriate,

- Audits of Medicare providers, including health maintenance organizations, and

- Fraud and abuse detection and prevention.

The HIPAA provides a stable, increasing funding source for contractor payment safeguard activities through the year 2003, by creating the Medicare Integrity Program (MIP). Prior to MIP, payment safeguard activities were subject to fluctuations of funding levels from year to year because they were part of HCFA's discretionary appropriation. With a dependable funding source, HCFA will have more money to invest in payment safeguard activities, as well as the flexibility to invest in new and innovative anti-fraud and abuse strategies.

The BBA builds on the anti-fraud and abuse provisions of HIPAA and gives HCFA more authority through its anti-fraud and pro-efficiency measures. Under this new law, HCFA has more authority to keep bad health care providers out of the Medicare program, exclude providers who are found to be abusing the program, and impose monetary penalties on providers as necessary. For instance, the BBA gave HCFA the authority to require durable medical equipment (DME) suppliers, home health agencies, and other types of provider facilities that have had a high rate of "fly-by-night" providers to post a surety bond of at least $50,000 before they are certified for participation in the Medicare and/or Medicaid programs.

The Program Integrity Strategy

We have identified four key payment safeguard principles that help promote the fiscal integrity of HCFA's programs. These principles make up our strategy for combating fraud and abuse in the Medicare and Medicaid programs: Prevention, Detection, Enforcement, and Coordination.

Fraud prevention means paying right the first time through such measures as, changing Medicare payment methodologies to make it harder for fraud to occur, keeping convicted criminals out of the program, requiring providers to post surety bonds, and collecting information, such as Social Security Numbers and Employer Identification Numbers, to track abusive providers. **Detection** means catching and recovering improper payments quickly by analyzing our data, monitoring utilization trends, and following-up on beneficiary reports of

improperly paid claims. **Enforcement** means taking action against those who abuse the Medicare and Medicaid programs through administrative remedies. These include suspending payments, collecting overpayments, disenrolling bad providers, imposing civil monetary penalties, and/or referring cases to the OIG. **Coordination** means working with all of our partners, providing case support for law enforcement, developing fraud alerts and fraud databases, and working with beneficiaries and providers to stop fraud and abuse.

Operation Restore Trust

A major initiative launched during FY 1995 and FY 1996, "Operation Restore Trust" targeted fraud and abuse in skilled nursing facility, home health care, and durable medical equipment services in five States. Together with the Office of Inspector General (OIG), the Administration on Aging, the Department of Justice, and the State Medicaid Fraud Control Units (MFCUs), HCFA worked to identify and investigate questionable billing patterns, and to develop a model for the successful prosecution of fraudulent or abusive providers or organizations. Due to the successes of the demonstration HCFA has now made this a part of our regular program by incorporating this coordinated approach to program integrity into the way we do business.

Other Anti-fraud Initiatives

The steadily increasing volume of investigations, indictments, and convictions against home health agencies has led to a great deal of publicity and concern about home health care fraud. In response to this concern, in September 1997, President Clinton and Secretary Shalala announced an unprecedented **Home Health Moratorium** on the entry of any new home health agencies into Medicare while we set up new rules to fight fraud and abuse by keeping unprepared and fly-by-night operations out of Medicare. This moratorium was lifted in January 1998. The new anti-fraud mechanisms for home health include requiring home health care companies to meet capitalization requirements and post a bond before starting business, making HHAs serve at least ten patients before being allowed into the Medicare program, and checking into possible conflicts of interest between HHAs and related business interests to ensure Medicare is not billed for inflated costs of services used by an HHA.

Prospective Data Sharing is an initiative involving agreements with major insurance companies to exchange enrollment information that permits us to identify MSP situations before we pay.

HCFA is actively transforming its computer technology to keep pace with the many rapid changes in the health care field and the explosive growth in new providers. The **National Provider Identifier (NPI)** is an industry-wide unique identifier for providers and suppliers. Databases that contain a record of all providers and suppliers who bill Medicare will be

created and made available to the Medicare contractors so they can automatically deny or give greater scrutiny to claims associated with abusive billers. The **Health Care Integrity and Protection Data Bank,** maintained by the Health Resources and Services Administration will include information on providers, suppliers and practitioners that have been found guilty of health related adverse actions through an adjudicated process.

HCFA, under the **National Medicaid Fraud and Abuse Initiative**, will continue to assist the OIG, the MFCUs, and Program Integrity Units in their role of prosecuting fraudulent providers; ensure all States are aware of fraudulent activities and scams occurring nationwide; promote consistency by developing national standards; form a National Fraud and Abuse Technical Advisory Group composed of HCFA and State agencies; and, develop a model legislative fraud and abuse package for States that builds on the best practices of States who already have similar legislation.

HCFA has also devoted greater emphasis on Medicaid fraud through formation of the Medicaid Fraud and Abuse Coordinating Council and the Medicaid Central Office/Regional Office Network. These projects help coordinate increased cooperation with States and other entities. HCFA's partnerships with States' Surveillance and Utilization Review Systems and MFCUs have facilitated detection, referral, and prosecution of Medicaid fraud.

Goal 5 - Provide Leadership in the Broader Public Interest to Improve Health

Coverage

Over the past 30 years, we have developed a coverage process that assures access to medical advances for Medicare beneficiaries, while protecting them from services whose effectiveness is unproven. One of HCFA's greatest challenges in administering the Medicare program is to maintain a dynamic decision-making process that produces consistent coverage guidance in the face of rapid changes in medical technology and health care delivery.

Medicare has emerged as a leader in the move toward such evidence-based decision making for coverage policy. We rely on state-of-the-art technology assessment and on agencies such as AHCPR, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Department of Veterans Affairs (VA), the Department of Defense (DOD) as well as the advice of the medical community and private sector studies. Our own extensive reimbursement data contain additional useful information for assessing the effectiveness of all varieties of medical care. The experience from our program can benefit the entire health care marketplace.

Furthermore, the sheer numbers of beneficiaries that we serve and the wealth of information that we possess about them makes Medicare and Medicaid an important force in the market. We recognize that our coverage process also controls services provided by managed care plans that serve Medicare beneficiaries. Not only is the share of Medicare and Medicaid patients in managed care plans growing rapidly, but plans must provide these enrollees with the same benefits that fee-for-service beneficiaries enjoy. As a result, managed care plans have an increasing interest in our process being as scientific and thorough as possible.

Partnering with States to Regulate Health Insurance

HCFA has long been responsible for regulating and monitoring Medigap insurance. As a result of HIPAA implementation activities for health insurance portability, HCFA has assumed a new role in relationship to State regulation of health insurance and health coverage. We work closely with the States and the NAIC to get their views and comments on the policy issues and regulatory processes. Also, we met with many other State groups, such as the National Governors' Association and the American Public Welfare Association's National Association of State Medicaid Directors. As we communicate with the States about regulatory processes, we are educating each other, bringing people together to talk and share experiences, with the common goal of using our resources wisely.

The HIPAA provides for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets. The "portability provisions" of HIPAA, will allow millions of Americans to enjoy greater security in their health care coverage. The law provides for shared responsibilities for the Secretaries of HHS, Labor, and Treasury. HHS, through HCFA, is working with the other Departments in implementing the group market provisions. In addition, HCFA has the sole responsibility for implementing and overseeing the provision of insurance protection in the individual market.

The group market provisions of HIPAA affect group health plans (generally, plans sponsored by employers or employee organizations or both). These HIPAA provisions are designed to improve the availability and portability of health coverage by limiting exclusions for preexisting conditions; providing credit for prior health coverage; providing new rights that allow individuals to enroll for health coverage when they lose other coverage or have a dependent; prohibiting discrimination in enrollment and premiums; guaranteeing availability of health insurance coverage for small employers and renewability of coverage in both the small and large group markets.

HIPAA provides for the enforcement of the small group and individual market provisions by States. However, if a State fails to enforce the Federal statutory provisions and does not choose to implement an acceptable alternative mechanism, then the statute provides for Federal enforcement of these provisions. It was generally not anticipated by Congress that Federal enforcement would be necessary. The expectations were that States would implement/enforce the legislation. To date five States -- California, Missouri, Rhode Island, Massachusetts, and Michigan -- have not passed conforming legislation, thus requiring HCFA to assume enforcement responsibility. Other States have opted not to implement some aspect of the insurance reform, thus requiring the Federal government to assume a more active role.

In order to implement and enforce HIPAA provisions, HCFA, among other things, must collect and review documentation regarding policy forms for compliance, regulate certificates of prior creditable coverage, and monitor marketing of individual policies. Therefore, we have been working closely with State officials and have developed very positive working relationships so that workers and their families in these States can benefit from this law as soon as possible.

Research Activity

The goal of HCFA's research, demonstration, and evaluation program is to provide timely, reliable information required for informed and rational decision making in the Medicare and Medicaid programs.

This goal is pursued through four primary objectives: (1) To monitor and evaluate performance of HCFA programs in terms of access, quality, efficiency and costs; (2) To further refine existing payment systems and to develop new payment, cost containment, and financing systems; (3) To develop new approaches to meet health care needs of vulnerable populations; and (4) To develop information systems to improve consumer choice and health status.

Exploring Methods of Payment: Medicare

One of the most difficult issues for Medicare as a purchaser of health care is how to pay for managed care. Since the Medicare program is limited by law in its ability to use alternative ways of paying for health care, we have used our authority to set up demonstration projects around the United States to test alternatives for the future.

HCFA's research was critical to numerous changes to the Medicare program recently mandated in the BBA. HCFA's research provided further evidence that there was selection and payment bias in Medicare risk plans. This information lead to a proposal to reduce the payment to managed care organizations by 5 percent. Subsequent action in the BBA reduced rates of increase for managed care payment levels and also provided for implementation of risk adjustment by January 1, 2000. In addition, HCFA research has provided the basis for the requirement to establish prospective payment systems for skilled nursing facilities, home health agencies, inpatient rehabilitation hospital care, and hospital outpatient services.

Another HCFA-funded study that influenced the BBA provisions was conducted by Mathematica Policy Research (MPR) entitled, "The Consequences of Paying Medicare Health Maintenance Organizations (HMO) and Health Care Prepayment Plans (HCPPs) Their Costs." This study examined the cost effectiveness of these cost-based contracting options with respect to fee-for-service and the risk contracting program during calendar year 1993. MPR found that costs to HCFA increased substantially under the cost HMO and HCPP programs. Furthermore, most of the cost-based plans were found to have favorable selection. As a result of these findings, MPR suggested that HCFA would save money by phasing out cost and HCPP contracts for HMOs, allowing plans to either convert to a risk contract or to end contracting with HCFA entirely. The BBA will eliminate both cost reimbursement contracts and HCPPs for Medicare managed care organizations.

Numerous demonstrations mandated by the BBA parallel demonstration efforts HCFA has already initiated. These reflect the leadership HCFA has taken in developing innovating and complex changes to the Medicare and Medicaid programs, such as Competitive Pricing for HMOs, Third Party Enrollment for HMOs, Competitive Bidding for Labs and DME, making PACE a permanent program, and a voluntary national program for Graduate Medical Education.

HCFA research continues to refine methods of health status based risk adjustment using encounter data. These methods are sufficiently developed that HCFA will begin implementation of health status risk adjusted payments to Medicare HMOs in 2000, as mandated by BBA.

In 1997, an initiative was begun to assess and ensure that accurate and comprehensive encounter data are being reported by sites participating in the Medicare Choices demonstration. Failure to submit accurate and comprehensive encounter data will have serious payment implications that could result in a substantially lower payment rate under the risk adjustment payment methodology used in this demonstration. Accurate encounter data is also required for the cost and use of services analyses that are part of the evaluation of the overall demonstration.

Looking to the future, HCFA will conduct design work related to the development of an Integrated Post Acute Care System. HCFA intends to investigate how to create an infrastructure of post acute and long term care (LTC) payment and delivery systems that are better integrated and more flexible in meeting the needs of beneficiaries with chronic illnesses and disabilities.

In connection with LTC, in 1997, HCFA began a study to examine and report on possible refinements to the resource utilization groups version III (RUG III) methodology for classification of skilled nursing facilities (SNFs) residents based on their predicted resource consumption. This study will examine the components of another resident classification system, the Nursing Severity Index (NSI) and determine if items contained in the NSI could improve the predictability of the RUG III system. The study will be conducted using extant resident level information and facility resource use data from a sample of SNFs in 12 States.

Exploring Methods of Payment: Medicaid

In the Medicaid arena, many States have been actively studying new ways to implement managed care, taking advantage of HCFA's authority, through waivers, to permit new service and payment designs. Medicaid's home and community-based services waiver program affords States the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals.

Section 1115 of the Social Security Act provides broad discretion to waive certain laws pertaining to Medicaid in order to conduct experimental, pilot or demonstration projects. These demonstrations frequently finance services to more low-income and uninsured people through new program efficiencies. Currently, 48 States offer some form of managed care expanding coverage to many persons who were previously uninsured.

User-Friendly Data

HCFA recently awarded the Research Data Assistance Contract (ResDAC) to the University of Minnesota School of Public Health, in a consortium with the Boston University, School of Medicine and Dartmouth College Medical School. The purpose of the contract is to increase the amount of independent research and the number of researchers skilled in accessing and using HCFA data bases for studies. ResDAC is developing training databases for using population-based studies. These databases will be structured to resemble actual HCFA files. Researchers will be able to gain experience in file linking, data element selection and testing of various analytical tools, and statistical procedures. Our plans call for the eventual release of these training databases as a public use file on the HCFA Home Page.

Goal 6 - Foster Excellence in the Design and Administration of HCFA's Programs

Standard Systems Maintainers

When Medicare was first implemented thirty years ago, each of the Medicare contractors used its own payment system to pay claims. Legislative and other program changes had to be separately programmed for each of these systems. Over the years, the contractors began to subcontract with systems maintainers for these services, and in 1996 there were approximately eighteen maintainers. To become a more effective administrator of Medicare, we are working to consolidate the Medicare payment systems into three standard systems, one for intermediaries, one for carriers, and a third for the durable medical equipment carriers, each with an integrated accounting system. This will simplify current operations and enable HCFA to implement change control management processes and ensure that the highest priority changes are made first. Because of continued problems with contractor reporting for the financial statement, we have also begun to design an integrated financial system that will incorporate accounting and reporting processes into the three selected standard systems. This systems change is necessary before HCFA can achieve substantial compliance with the Federal Financial Management Improvement Act.

Data Improvement Initiatives

We are working with the States and the health care industry to implement the BBA provision requiring all States to submit claims data (including encounter data) through the Medicaid Statistical Information System (MSIS) beginning January 1, 1999. Currently more than 30 States participate on a voluntary basis. We have initiated a consultation process with the States to develop an implementation plan as well as enhanced methods for the receipt, transmission, and reporting of Medicaid data. We have also solicited input and assistance from other users, including the research community. Total participation by all States in MSIS will for the first time provide for a unique national standardized Medicaid database, reflecting an annual volume of approximately 1.5 billion records of Medicaid statistical information.

Millennium Conversion

HCFA's goal is to have all systems renovated, tested, and implemented with a millennium-compliant version by December 31, 1998. Compliance efforts are well underway, and HCFA's Millennium Team has identified more than 100 potential systems that may need to be converted and tracked.

Information Technology Investment Process

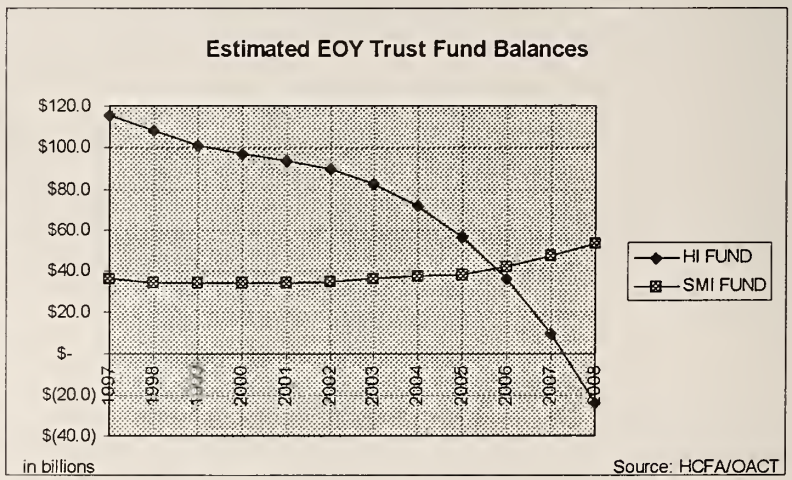
In accordance with the Clinger Cohen Act of 1996, HCFA is implementing an Information Technology (IT) Investment process. At this stage of implementation, all project owners of "major" IT investments (those investments that exceed $10 million over a 5-year period, and are essential for the accomplishment of Agency business-drivers) are required to document their analyses (e.g., return on investment, risk, etc.). To be fully successful, implementation of the full process must be phased. During this transition period, resources are focused on ensuring (1) that the Agency's major investments are in compliance with the OMB guidance; and (2) that other high-priority investments, are consistent with HCFA's IT architecture. HCFA will begin to move incrementally toward full implementation of the IT investment process during FY 1998 and into the FY 1999-2000 cycles.

Challenges

STATUS OF THE TRUST FUNDS

Hospital Insurance (HI)

The 1998 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2008.



The Trustees (the Secretaries of the Treasury, Health and Human Services, Labor, the Commissioner of Social Security, and two public trustees) recommended the earliest possible enactment of legislation to reduce growth in the HI program costs and extend the date of exhaustion of the HI Trust Fund. The Balanced Budget Act remedied the imminent depletion of the HI Trust Fund. One provision will fund only the first 100 home health agency (HHA) visits that are post-hospital or post-skilled nursing facilities (SNF) care from the HI Trust Fund. Other provisions will change the payment process for outpatient hospital clinics, HHAs, and SNFs to the prospective payment system (PPS). Additional legislation will be needed for longer term corrections. The BBA also establishes a Bipartisan Commission on the Future of Medicare to develop long-term solutions to meet the challenges of the baby boom generation.

Supplementary Medical Insurance (SMI)

The SMI trust fund is expected to remain adequately financed into the indefinite future, but only because current law provides for the establishment of program financing each year based on an updated calculation of expected cost per SMI beneficiary. The BBA also remedied a provision of the law that would have had premium income cover a declining share of program

costs. Premiums accounted for 24 percent of revenue in fiscal year 1997. Prior to the passage of the BBA, premiums were estimated to account for 16 percent in calendar year 2006 and a progressively lower share thereafter.

The Demographic Challenge

Demographic trends pose a long-term challenge to the sustainability of the trust funds. There are expected to be 3.6 workers per HI beneficiary when the baby boom generation begins to reach age 65 in 2010. Then the worker/beneficiary ratio is expected to decline to 2.3 in 2030 as the last of the baby boomers reaches age 65. The ratio is expected to continue declining thereafter (but more gradually) as life expectancy continues to lengthen. Since 1966, the Medicare Part A beneficiaries ages 85 and over have increased from 6.2 percent to 11.6 percent of all aged beneficiaries enrolled in HI.

HI expenditures are projected to grow rapidly as a fraction of workers' earnings, from 3.4 percent in 1997 to about 7.8 percent in 2070. As a fraction of the Gross Domestic Product (GDP) expenditures would grow somewhat more slowly, from 1.69 percent in 1997 to about 3.41 percent in 2070. SMI expenditures are expected to continue to grow faster than the economy as a whole. SMI outlays were less than 1 percent of the GDP in 1997 and are projected to grow to about 2.48 percent by 2020.

DISBURSEMENTS AS A PERCENT OF GDP

Calendar Year	HI	SMI	Medicaid	Total
1997	1.69	0.93	2.2	4.82
2000	1.61	1.07	2.3	4.98
2005	1.65	1.35	2.6	5.60
2020	2.22	2.48	3.1	7.80
2070	3.41	3.31	3.6	10.31

SMI as a percent of GDP will grow larger because of the shift of HHA from HI to SMI. Also, Outpatient PPS picks up a larger share of payments in the out years.

HEALTH DATA

HCFA is the largest consumer and maintainer of health data in the world. There are a number of major initiatives underway to move HCFA into the twenty-first century. The most critical of these is planning for the millennium.

Millennium

HCFA's goal is to have all systems renovated, tested, and implemented with a millennium-compliant version by December 31, 1998. Compliance efforts are continuing, and HCFA's Millennium Team has identified more than 100 potential systems that may need to be converted and tracked.

The issue of data exchanges complicates the millennium issue for HCFA since we rely heavily on Medicare contractors for data. Even if all of HCFA's computer systems become completely millennium-compliant, the agency must also consider what could happen to exchanges of data with contractor systems and those who interface with contractor systems. Thus, even if HCFA and Medicare contractor systems are all millennium-compliant, we need to take steps in the event those who exchange data with the contractors, i.e., States, providers, Railroad Board etc., do not deliver compliant data to the contractors. In these cases, we are exploring ways to bring the noncompliant data into a format that can be used by systems that have already been converted. Other issues include the problem of finding and keeping programmers in the competitive market, the necessity of coordinating date formats and time frames between HCFA and external partners, and the possible sharing of HCFA's testing facility with the contractors. To date, the cost of conversion efforts have turned out to be much higher than originally anticipated

Systems Compliance

Because of continued problems with contractor reporting for the financial statement, we are working on the design of an integrated financial system that will incorporate accounting and reporting processes into the three selected standard systems. This measure is necessary before HCFA can achieve substantial compliance with the Federal Financial Management Improvement Act.

Information Systems Security

HCFA's business needs and information technology capabilities are changing the way HCFA is doing business. We have an ever expanding set of partners and customers; we want to conduct business more quickly using on-line mode; we have a presence on the Internet and wish to leverage its capabilities in greater ways. This environment presents new opportunities as well as new information systems security risks that HCFA must manage. We recognize that, with HCFA's missions increasingly dependent on information, a strong systems security infrastructure is essential to HCFA's success. The Chief Information Officer is introducing a HCFA Systems Security Initiative to build an effective security infrastructure.

Health Data Standards

Health data standards for electronic health care commerce are mandated by HIPAA. The statute requires HCFA, on behalf of HHS, to adopt standards for both data and privacy of health insurance transactions. The first challenge to be faced will be the logistical challenge of analyzing and responding to the high volume of public comments expected on the proposed regulations. An average of 10,000 comments is expected for each of the six documents. Since these standards will apply to the entire health care industry, rather than just to Federal programs, these comments will represent a wide range of viewpoints. The next challenge will be synthesizing these disparate views into final rules that meet the needs of the industry as a whole. Finally, HCFA will be called upon to facilitate the industry's implementation of the standards, and to implement the standards in the Medicare and Medicaid program.

CLAIMS PAYMENT ACCURACY

The FY 1997 financial statement audit reviewed claims payment accuracy in their assessment of HCFA's compliance with laws and regulations. The audit found that from $12.1 to $28.4 billion of the $177.4 billion in processed fee-for-service claims paid by HCFA in FY 1997, were improper payments. Although 98 percent of the claims were paid correctly based on information submitted to the contractors, when subsequent medical documentation was requested from providers and the services were reviewed, the OIG found an improper error rate of 7 to 16 percent with a point estimate of 11 percent. Of the errors identified through this look-behind review of claims, the OIG estimated that approximately 44 percent of the errors were due to insufficient or missing medical documentation. Another 36 percent of the errors were due to a lack of medical necessity.

By comparison, the FY 1996 audit found that the dollar value of improper Medicare benefits payments ranged from $17.8 to $28.6 billion, or about 14 percent of the $168.6 billion in processed fee-for-service payment reported by HCFA in FY 1996. Although the FY 1997 rate of improper payments is three percentage points less than that in FY 1996, the OIG cannot conclude that the FY 1997 error rate is statistically different from that projected in FY 1996. This means that the decrease could be attributed to any number of factors, such as the fact that different types of claims with different dollar values were selected in FY 1997.

The OIG recommended that HCFA continue to pursue the corrective action plan (CAP) that was developed as a result of the FY 1996 audit. HCFA concurs and will continue its aggressive corrective actions. Our CAP is designed to decrease the error rate by doing more claims review, including documentation review, and encouraging providers to properly document the services they provide to Medicare beneficiaries. We will continue to pursue

activities that will increase our ability to pay claims correctly the first time, increase our prepayment savings, and further reduce the Medicare claims payment error rate. The audit has demonstrated the need for HCFA to increase oversight to ensure provider compliance with Medicare reimbursement rules and regulations.

FINANCIAL REPORTING

Accounts Receivable

The audit of the financial statements focuses on the amounts reported to determine if they are accurate and can be supported by subsidiary documentation. The Contractor Financial Report, Form HCFA-750/751, submitted each year by the Medicare contractors is one of the primary sources of the amounts shown on the financial statements, and the auditors focus on how these amounts are derived as part of their audit. In 1997, Medicare accounts receivables were not auditable because of a lack of an integrated receivable/accounting system and the failure of many contractors to provide substantiation for the amounts reported. The auditors had trouble with receivables that could not be reconciled due to the lack of a general ledger and other documentation. The ultimate solution is an integrated accounting system. HCFA is currently reviewing systems options and working on the design of an integrated accounting system.

Debt Collection Improvement Act (DCIA)

Under the DCIA, federal agencies are required to refer debts to the Treasury Offset Program (TOP) and transfer debts to a Designated Debt Collection Center (DCC) for cross servicing once they have become 180 days delinquent. Debts referred to the TOP are housed in the National Interactive Database and matched to federal payments for potential offset, although agencies continue to pursue collection of these debts unless the statue of limitations has been reached. HCFA is required to discontinue collection activity on debts transferred to a DCC for cross servicing. The DCC performs a variety of collection activities including sending additional demand letters, referring information to credit reporting agencies, skiptracing, referring debts to the TOP, referring debts to private collection agencies, negotiating repayment agreements, and eventually referring debts to the Department of Justice for litigation if necessary. HCFA has actively embraced DCIA and begun the task of validating and referring its delinquent debts to a DCC.

BENEFICIARY PROTECTIONS

As we strive to expand beneficiary choice, we have taken steps to protect Medicare managed care enrollees. We have implemented the Anti-gag Rule policy to assure that beneficiaries have information about all the health care options appropriate for them; implemented the

Physician Incentive regulation so that financial arrangements between physicians and health plans will be disclosed; taken the lead in setting quality standards for managed care through the implementation of HEDIS® for Medicaid and Medicare and through our partnership with the AHCPR, to name a few. We are planning to expedite the managed care grievances and appeals process. We also need to expand the new health insurance portability rules to improve access to Medigap insurance plans, and make it possible for beneficiaries to try managed care and return to fee-for-service and Medigap coverage if they decide to do so.

BALANCED BUDGET ACT (BBA) OF 1997

HCFA is charged with implementing a number of changes to the Medicare and Medicaid programs as a result of the BBA. We plan to implement the most important provisions on schedule, and have advised interested parties that other provisions may be delayed. This is due in part to the diversion of programming resources to ensure that millennium changes to accommodate the year 2000 are completed. In addition, some changes fall in areas within HCFA where there are a limited number of analysts skilled in the specific topic, and the implementing regulations must be handled sequentially.

MEDICARE CONTRACTOR OVERSIGHT

HCFA's oversight of Medicare contractors has been reduced over the last few years. This is due to growing responsibilities in HCFA related to fraud and abuse, the children's health program, managed care expansions, implementation of new legislation, unanticipated responsibilities related to insurance reform, and other demands. We are currently reviewing options to determine the best methods to fulfill contractor oversight responsibilities.

Financial Statement Highlights

ASSETS

HCFA's balance sheet shows $171 billion in assets compared to $181 billion in 1996. This difference is primarily due to the Medicaid accounting policy change in anticipated appropriations discussed below. There were also minor declines in trust fund balances and investments, due to the lower levels of the HI trust fund. The bulk of these assets are in the Medicare Trust Fund Investments of $151 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." The next largest asset is the Treasury Fund Balance of $13.4 billion, most of which pertains to the Medicaid appropriation.

Total net accounts receivable is $2.5 billion. Most receivables are the result of Medicare program overpayments made to providers and beneficiaries. For the most part receivables are collected through offset of payments due providers and beneficiaries on an ongoing basis throughout the year. Included in this balance are amounts for claims in which Medicare should be the secondary rather than the primary payer and amounts currently under dispute.

LIABILITIES

Liabilities were $42 billion in 1997 an increase from $41 billion in 1996. This was primarily due to increases in Medicare and Medicaid payables. Payables represent the value of services provided to beneficiaries but not yet billed, or services billed but not yet paid in both the Medicare and Medicaid programs. A new estimating methodology was developed during 1997 to enhance the accuracy of the Medicare payables. The delay between the date services are rendered and payment is made is a normal situation in health insurance programs, and most of these liabilities will be liquidated in FY 1998.

NET POSITION

The Cumulative Results of Operations, for the most part, represent Medicare Trust Fund investments, reduced by the Medicare and Medicaid payable. The FY 1997 Total Net Position of $129 billion is lower than it was in FY 1996 primarily because HCFA returned $9 billion in unexpended appropriations (Payments to the Health Care Trust Funds) to the Department of the Treasury during FY 1997.

REVENUE AND FINANCING SOURCES

Revenues for the HI Trust Fund from Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) were $112.7 billion compared to $106.9 in 1996. Income from interest was $9.6 billion. All other income was $5.9 billion.

The SMI program is financed primarily by a general fund appropriation (Payments to the Health Care Trust Funds), which provided $59.6 billion in 1997, and by monthly premiums paid by beneficiaries. The SMI premium is set by statute and was $42.50 beginning January 1996, and $43.80 beginning January 1997. In FY 1997, the premium accounted for $19.1 billion, while interest yielded $2.3 billion.

The total Medicare Trust Fund income of $209.4 billion in FY 1997, compared to $198.5 for FY 1996. HI Trust Fund income was $128.2 billion and SMI income was $81 billion.

Medicaid is financed by a general fund appropriation provided by Congress. In 1997, the appropriation was $96.6 billion compared to $91.4 billion in 1996.

EXPENSES

Total Medicare expenditures including benefit payments, Peer Review Organization and Medicare Integrity Program spending, and administrative costs, totaled $211.9 billion, an increase of 5 percent over FY 1996. HI Trust Fund expenditures were $138.6 billion in FY 1997 and SMI expenditures were $73.3 billion. The Medicare Benefit Payments line includes estimated improper payments of $12.1 to $28.4 billion. This represents the results of a sample by the Office of the Inspector General of Medicare claim payments. This is discussed in greater detail in the Response to the Auditors' Opinion.

The HI and SMI Trust Fund incomes to expense ratios were a mixed picture in FY 1997. The HI Trust Fund took in 93 cents for each dollar expended. The SMI Trust Fund took in $1.11 for each dollar expended. One of the most important aspects of a financial analysis related to HCFA is the recognition of the issue of long term solvency of the HI Trust Fund, which is discussed in the Challenges section. Based on assumptions about demographics, employment, and tax rates, actuarial estimates predict that the fund will become insolvent in the year 2010.

Medicaid expenses were $96.6 billion compared to $91.4 in 1996. This represents expenses incurred by the States and Territories that were reimbursed by HCFA during the fiscal year plus accrued payables.

CHANGES IN FINANCIAL REPORTING

Medicaid

HCFA's FY 1996 financial statement showed the Medicaid Program in a negative fund position because fund authority was not believed to be available to offset the balance of the payable that was not covered by the unexpended portion of the Medicaid appropriation. A review of appropriation language by the Office of the General Counsel indicates that the Medicaid appropriation provides for "indefinite authority" with specific language permitting payments to the States for the last quarter of FY 1997 for any unanticipated costs incurred during the current fiscal year. Since fund authority is available to cover all costs incurred for the current fiscal year, additional fund authority to cover the payable can be recorded, bringing the net position to zero.

SMI Premium Match

The SMI program is financed primarily by a general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums collected, and outlines the ratio for the match and the method to make the trust funds whole, with interest, if insufficient appropriation authority is available to match all premiums received in the fiscal year. The appropriation amount is based on an estimate calculated annually by the HCFA's Office of the Actuary (OACT) and can be insufficient in any particular year. In 1997, the appropriation was insufficient to match all premiums collected, and, therefore, the matching ceased prior to the close of the fiscal year. In cases like this, Section 1844 allows for a reimbursement to be made to the Part B Trust Fund from the following year's appropriation for Payments to the Health Care Trust Funds.

On the 1997 financial statement, we have shown the funds representing the unmatched premiums as a future funding requirement. This is consistent with OMB guidance for appropriated entitlement programs, which states that funds depending on an appropriation cannot be considered to be covered by budgetary resources until an appropriation has been approved.

Discussion of Auditors' Opinion

We have worked closely with the Office of the Inspector General (OIG) and their audit teams to assist them in understanding our very complex programs and the multitude of financial systems used to develop this financial statement. We continue to be hampered because the Medicare contractors do not have integrated accounting systems.

The Medicare and Medicaid programs are operated decentrally in a partnership with Medicare contractors and States and Territories. This arrangement provides HCFA with operating challenges that are unique within the Federal Government. Medicare and Medicaid claims are paid by 65 contractors and 57 States and Territories, using multiple systems and processes. This compounds the difficulty, complexity, and expense of making systems and operating changes. The systems that have been designed to pay medical providers and suppliers are segmented according to the type of medical service and the locality where it was provided. From the inception of the program, each contractor and State were allowed to have their own payment process and few have a standard general ledger. Over the last few years we have begun standardizing the claims processing systems and standardized interface requirements but each contractor continues to have their own method of operation.

The Medicare program is complex, because we serve beneficiaries, but pay providers. The relationship between the two is difficult to capture through the claims payment systems in a way that the cost can be tracked by beneficiary. For example, when a cost is incurred because a beneficiary receives a medical service, the payment is made to the medical provider. A doctor may bill Medicare biweekly for a group of beneficiaries and receive one check. Data are kept by beneficiary, but payment data may not easily reveal which beneficiaries are included when the payments are made. If an overpayment to a provider is inadvertently made in one payment cycle, it is withheld from the provider check the following payment cycle. Although program audits find that our systems are doing the job for which they were intended, i.e., ensuring eligibility of beneficiaries and providers, pricing out medical procedures, paying bills correctly, and making adjustment to provider accounts, the systems do not meet CFO Act and Federal Financial Management Improvement Act requirements since most contractors do not have a general ledger. We also have concerns about their readiness for the millennium.

The ultimate solution to the financial reporting problem at the Medicare contractors is shared standardized systems, improved oversight of contractor operations, and automation of the financial reporting process. We are currently analyzing contractor systems to determine how accounting and reporting processes can be incorporated into their design.

The Medicaid process is complicated by the Federal-State relationship. We must ask each State to provide relevant financial reporting that can be incorporated into HCFA's financial statement. States that receive federal funds are subject to a single federal audit.

Corrective Actions

In FY 1998 we will continue to work closely with the auditors, and concentrate our efforts on the areas that are keeping HCFA from an unqualified opinion.

The **accounts receivables** valued at $2.5 billion, have been a problem since the inception of the CFO report. It was HCFA's plan to attach an integrated accounting/accounts receivable system to the Medicare Transaction System, and after that project was canceled, to the contractor selected systems. Although our long range plan continues to focus on a contractor-based integrated accounting system, the millennium priorities have pushed this project further into the future. This makes our short term corrective action plan to improve receivable reporting even more important.

Our short term corrective action plan focuses on using the contractors' existing subsidiary systems to validate the quality of data, and to identify and document the audit trails necessary to support the data reported to HCFA. We have already requested that the Medicare contractors "snapshot" their systems at the end of each quarter to keep a complete audit trail including ledgers at the transaction level. We have scheduled visits by technical teams to Medicare contractors to review systems, reconcile financial data, and ensure that appropriate audit trails are available. The technical team will assess any short term system improvements that may be needed and identify any changes needed to the HCFA 750/751 reports. This information will result in revised policies and procedures that will be implemented nationwide.

The **cost report settlement** process, valued at $2.4 billion in Expenses in 1997, represents the net amount paid to providers based on fiscal intermediary (FI) audits of providers' cost reports. The cost report represents the costs incurred by a facility to provide Medicare services. Because this cost settlement audit process is targeted toward those providers and areas within the cost report most likely to be a risk to the Medicare program, it is not conducted on a random sample basis. This makes it more difficult for auditors. As shown in footnote 13, HCFA believes the cost report error rate to be in the range of one to 3 percent.

During the review of HCFA's **compliance with laws and regulations,** the auditors found that the median dollar value of improper Medicare benefits payment made during FY 1997 was between $12.1 and $28.4 billion with a midpoint of $20.3 billion, or about 11% of the $177.4 billion in processed fee-for-service payment reported by HCFA in FY 1997. These improper payments were detected by a "look-behind" review performed by medical review

staff. Medicare, like other insurers, makes payments based on a standard claims form. Providers are supposed to retain supporting documentation and make it available upon request.

By comparison, the FY 1996 audit found that the median dollar value of improper Medicare benefits payments ranged from $17.8 to $28.6, or about 14% of the $168.6 billion in processed fee-for-service payment reported by HCFA in FY 1996. Although the FY 1997 error rate is three percentage points less than FY 1996's, the OIG cannot conclude that the FY 1997 error rate is statistically different from that projected in FY 1996. This means that the decrease could be attributed to any number of factors such as the fact that different types of claims with different dollar values were selected in FY 1997. As the audit indicates, OIG obtained documentation for 98 percent of the claims. Most of the errors fell into four general categories: insufficient or no documentation errors, lack of medical necessity, incorrect coding, and noncovered/unallowable services. HCFA has developed a comprehensive corrective action plan (CAP) designed to further reduce the Medicare claims payment error rate. We will continue to work closely with our provider community to address these problems, and are actively exploring the use of commercial software to find better methods of detecting incorrect coding prior to payment.

The Chief Information Officer has introduced a HCFA **systems security** initiative in recognition of the gravity of our responsibility for the safekeeping of HCFA's valuable data and data processing facilities. The goals of the systems security initiative are to: (1) aggressively address the known vulnerabilities that were found through internal and external reviews, and (2) build the capability to maintain an effective security posture for HCFA's dynamically changing business environment. This goal will be accomplished by integrating security into every aspect of our information technology management activities enterprise-wide.

Limitations of the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990, (P.L. 101-576).

These financial statements have been prepared from HCFA's general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with the formats prescribed by the Office of Management and Budget. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal controls rests with management.

Principal Financial Statements

Chapter 2

COMBINED STATEMENTS OF FINANCIAL POSITION
AS OF SEPTEMBER 30, 1997

(Dollars in Millions)

	FY 1997
ASSETS	
Entity Assets:	
Intragovernmental Assets:	
Fund Balance with Treasury *(Note 2)*	$ 13,367
Investments *(Note 3)*	151,085
Anticipated Congressional Appropriation *(Note 4)*	1,101
Accounts Receivable	4
Trust Fund Investment Interest Receivable *(Note 3)*	2,849
Governmental Assets:	
Accounts Receivable, Net *(Note 5)*	2,485
Advances and Prepayments	12
Restricted Cash	45
Property and Equipment, Net	40
Total Entity Assets	170,988
Non-Entity Assets: Governmental Assets:	
Accounts Receivable, Net *(Note 6)*	77
Total Non-Entity Assets	77
Total Assets	**$ 171,065**
LIABILITIES	
Liabilities Covered by Budgetary Resources:	
Intragovernmental Liabilities:	
Accounts Payable	$ 10
Liabilities for Loan Guarantees	5
Uncollected Revenue due Treasury *(Note 7)*	193
Governmental Liabilities:	
Accounts Payable	54
Suspense Account Deposit Fund	4
Accrued Payroll and Benefits	15
Other Governmental Liabilities *(Note 7)*	41,706
Total Liabilities Covered by Budgetary Resources	41,987
Liabilities Not Covered by Budgetary Resources:	
Intragovernmental Liabilities: Accounts Payable	7
Governmental Liabilities: Accrued Leave	23
Total Liabilities Not Covered by Budgetary Resources	30
Total Liabilities	**$ 42,017**
NET POSITION *(Note 8)*	
Balances:	
Unexpended Appropriations	$ 65
Invested Capital	40
Cumulative Results of Operations	128,973
Future Funding Requirements	(30)
Total Net Position	**$ 129,048**
Total Liabilities and Net Position	**$ 171,065**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF OPERATIONS AND CHANGES IN NET POSITION FOR THE YEAR ENDING SEPTEMBER 30, 1997

(Dollars in Millions)

	FY 1997
REVENUES AND FINANCING SOURCES	
Direct Appropriations Expended	$ 96,556
Employment Tax Revenue *(Note 9)*	112,742
SMI Premiums *(Note 10)*	19,141
Federal Matching Contributions *(Note 10)*	59,615
Trust Fund Investment Interest	11,900
Finance Imputed for Cost Subsidies	10
Other Revenues and Financing Sources *(Note 11)*	6,087
Total Revenues and Financing Sources	**306,051**
EXPENSES *(Note 12)*	
Program or Operating Expenses	
Medicare Benefit Payments	207,455
(Includes estimated improper payments of $12.1-$28.4 billion). (Note 13)	
Medicaid Benefit Payments	96,556
Medicare Integrity Program	512
Administrative Expenses *(Note 14)*	2,899
Depreciation and Amortization	11
Bad Debts and Writeoffs	1,156
Imputed Cost Subsidies	10
Other Expenses	10
Total Expenses	**308,609**
Shortage of Revenues and Financing Sources Over Total Expenses	**$ (2,558)**
Net Position, Beginning Balance	125,365
Plus Prior Period Adjustment *(Note 15)*	15,247
Net Position, Beginning Balance as Restated	140,612
Shortage of Revenues and Financing Sources Over Total Expenses	(2,558)
Minus Non-Operating Changes *(Note 16)*	(9,006)
Net Position, Ending Balance	**$ 129,048**

The accompanying notes are an integral part of these statements.

NOTE 1: Summary of Significant Accounting Policies

Reporting Entity

The Health Care Financing Administration (HCFA) is a separate financial reporting entity of the Department of Health and Human Services (HHS). The financial statements have been prepared to report the financial position and results of operations of HCFA, as required by the Chief Financial Officers Act of 1990. The statements were prepared from HCFA's accounting records in accordance with the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 94-01. In addition, the financial statements satisfy certain provisions in OMB Bulletin 97-01 in effect for fiscal year (FY) 1997. OMB Bulletin 97-01 will be in effect in its entirety for the fiscal year ending September 30, 1998.

The financial statements cover all the accounts administered by HCFA. The Consolidating/ Combining Statement of Financial Position by Activity and the Combining Statement of Operations and Changes in Net Position by Activity (Financial Statements by Activity) for 1996 and 1997 are included in the Supplementary Section. The major accounts administered by HCFA are:

Medicare Hospital Insurance (HI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. The financial statements include HI Trust Fund activities administered by the Department of the Treasury (Treasury).

Medicare Supplementary Medical Insurance (SMI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. The financial statements include SMI Trust Fund activities administered by Treasury.

Medicaid

Medicaid, the health care program for low-income Americans, is administered by HCFA in partnership with the States. It is funded by the Grants to the States appropriation. Grant awards prepared by HCFA's Center for Medicaid and State Operations limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of HCFA's share of States' Medicaid costs. At the end of each quarter, States submit a report of their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued.

Medicare Integrity Program

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the Medicare Integrity Program, codifying the program integrity activities previously known as "payment safeguards." The Medicare Integrity Program contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI Trust Fund. Previously, payment safeguards were financed through HCFA's Program Management appropriation.

Program Management

The Program Management appropriation provides HCFA with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI Trust Funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds appropriation reimburses the Medicare HI Trust Fund to cover the Medicaid program's share of HCFA's administrative costs (see Note 14). User fees collected from Health Maintenance Organizations (HMO) seeking Federal qualification and funds received from other federal agencies to reimburse HCFA for services performed for them are credited to the Program Management appropriation. Costs relating to the Program Management appropriation are allocated between the Medicare and Medicaid programs based on HCFA's cost allocation system and are reported in the Medicare and Medicaid columns of the Financial Statements by Activity in the Supplementary Section.

The following accounts, if not specified otherwise, are reported in the Supplementary Section of this report, in the "All Others" column of the Financial Statements by Activity.

Program Management - Clinical Laboratory Improvement Program and Other User Fees

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. User fees are also charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund. This account operates as a revolving fund without fiscal year restriction.

Payments to the Health Care Trust Funds

The Social Security Act provides for payments to the HI and SMI Trust Funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of HCFA's administrative costs charged to the Program Management appropriation. To prevent duplicative reporting, the revenue and expenses of this appropriation are reported only in the Medicare HI and SMI columns of the Financial Statements by Activity.

Permanent Appropriations

A transfer of general funds to the HI Trust Fund in an amount equal to Self-Employment Contribution Act (SECA) tax credits is made through the Payments to the Health Care Trust Funds appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 1997 are adjustments for late or amended tax returns. The revenue and expenses for this account are reported only in the HI Medicare column of the Financial Statements by Activity.

The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of Old Age Survivors and Disability Insurance benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent for taxable years beginning in 1994. The revenues, resulting from this increase, are transferred to the HI Trust Fund. The revenue and expenses for this activity are reported only in the Medicare HI column of the Financial Statements by Activity.

Suspense Account

Agencies are required to deposit receipts expeditiously. Unidentified collections are deposited into a suspense account for immediate investment by Treasury while HCFA researches the actual application of funds.

Miscellaneous Fines, Penalties, and Forfeitures

Administrative fees and penalties assessed by HCFA on overdue FOIA debts are deposited into this account upon collection.

Interest Receipts

Interest collections from overdue debts are deposited into miscellaneous receipt accounts managed by Treasury.

Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

Basis of Accounting

Transactions are recorded using both the accrual and cash basis of accounting, and a budgetary basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method and the budgetary method, expenses are recognized when cash is outlayed.

HCFA uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

HCFA uses the cash basis of accounting in the Medicaid program to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to HCFA as of the end of the fiscal year.

Budgetary accounting facilitates compliance with legal constraints and controls over the use of Federal funds. HCFA uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS.

Funds with Treasury and Cash

Cash receipts and disbursements are processed by Treasury. Funds with Treasury are primarily available to pay current liabilities. HCFA also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.

The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits Account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits Accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks. The total amount of time account balances at the Medicare contractors' commercial banks is reported as "restricted cash" on the Combined Statements of Financial Position.

Investments

Sections 1817 (c) for HI and 1841(c) for SMI of the Social Security Act require that trust fund holdings not necessary to meet current expenditures be invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

Liabilities

Liabilities represent amounts owed by HCFA as the result of transactions that have occurred. However, no liability can be paid by HCFA without an appropriation. Liabilities for which an appropriation has not been enacted are classified as unfunded liabilities.

Retirement Plans

HCFA employees participate in the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to 7 percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management (OPM).

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which HCFA is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 1997, HCFA has canceled over $79 million in cumulative obligations to FYs 1992 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FYs 1993 through 1997 related to canceled appropriations, HCFA anticipates an additional $3.5 million will be paid from current year funds for canceled obligations.

Accounting Changes

The following accounting changes were made in FY 1997. Additional data, including restatements relating to FY 1996 amounts, can be found in the Supplementary Section.

1) Collection of Fines & Penalties

Prior to FY 1997, collections of fines and penalties from debtors were deposited in Miscellaneous Fines, Penalties, and Forfeitures. In FY 1997 this activity was transferred to the Hospital Insurance Fraud and Abuse Control Program, pursuant to Public Law 104-191.

2) SMI Premium Matching Contribution

In FY 1997, the Payments to the Health Care Trust Funds appropriation was insufficient to match all of the SMI premiums collected from third parties. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match, as well as the method to make the trust funds whole, with interest, if insufficient money is available in the appropriation to match all premiums received in the fiscal year.

On the Combined Statements of Financial Position, HCFA has recognized the amount representing the unmatched premiums as a future funding requirement. This is consistent with OMB guidance for appropriated entitlement programs, which states that funds depending on an appropriation cannot be considered to be covered by budgetary resources until an appropriation has been approved by the Congress.

3) Medicaid Claims Incurred But Not Reported (IBNR)

HCFA reports a liability for the Medicaid program that represents claims incurred by the States as of September 30 that have not yet been reported to HCFA. In FY 1996, HCFA recognized as an unfunded liability the portion of the IBNR amount that exceeded the remaining unexpended appropriation. However, a review of appropriation language by Office of General Counsel (OGC) has determined that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Accordingly, this change was made for FYs 1997 and 1996. Medicaid accounts have been restated to reflect this change in policy.

4) Imputed Cost Subsidies

Prior to FY 1997, OPM subsidized and reported major portions of the pension costs of other Federal agencies. In FY 1997 Federal agencies are required to impute the full cost of the subsidy and to report the amount as a financing source and expense.

Systems Compliance

HCFA's goal is to have all systems renovated, tested, and implemented with a millennium-compliant version by December 31, 1998. Compliance efforts are continuing, and HCFA's Millennium Team has identified more than 100 potential systems that may need to be converted and tracked. Because of continuing problems with contractor reporting for the financial statements, we have also begun to design an integrated financial system that will

incorporate accounting and reporting processes into the three selected standard systems to be used by the Medicare contractors. This measure is necessary before HCFA can achieve substantial compliance with the Federal Financial Management Improvement Act.

Fund Classes and Account Symbols

HCFA's financial statements present the consolidated activity of four fund classes: Trust, Revolving, General, and Other. The financial totals comprise the following appropriations/funds with related account symbols:

Trust Fund Accounts

Title	Receipt Account	Expenditure Account
Supplementary Medical Insurance Trust Fund		**7520X 8004**
Premiums Collected for Supplementary Medical Insurance Trust Fund	**7520X 8004.5**	
Premiums Collected for Disabled Supplementary Medical Insurance	**7520X 8004.7**	
Other, Federal Supplementary Medical Insurance Trust Fund	**7520X 8004.29**	
Gifts, Supplementary Medical Insurance Trust Fund	**7520X 8004.42**	
Federal Hospital Insurance Trust Fund		**7520X 8005**
Premium Collected For Uninsured Hospital Insurance Trust Fund	**7520X 8005.9**	
Other, Federal Hospital Insurance Trust Fund	**7520X 8005.29**	
Gifts, Federal Hospital Insurance Trust Fund	**7520X 8005.42**	
Hospital Insurance Fraud & Abuse Control Program Civil Monetary Penalty Assessments	**7520X 8005.047**	
Hospital Insurance Fraud & Abuse Control Program Penalties Damages	**7520X 8005.049**	
Health Care Fraud & Abuse Control		**75 7 8393**

Revolving Funds

Title	Receipt Account	Expenditure Account
Health Maintenance Organization - Loan & Loan Guarantee Fund		**75 X 4420**

General Funds

Title	Receipt Account	Expenditure Account
Miscellaneous Fines & Penalty Forfeitures	**75 7 1099**	
General Fund - Proprietary Interest	**75 7 1435**	
General Fund - Proprietary Receipts Other - All Other	**75 7 3220**	
Grants to States for Medicaid		**75 X 0512**
CLIA		**75 X 0511**
Seif-Employment Contribution Act Credits, HCFA		**75 X 0513**
Old Age & Survivors & Disability Insurance (OASDI)		**75 X 0585**
Program Management HCFA		**75 7 0511**
Payments to Health Care Trust Funds HCFA		**75 7 0580**

Other Fund

Title	Receipt Account	Expenditure Account
Suspense, HCFA	**75 X 6875.05**	

NOTE 2: Entity Fund Balances (Dollars in Millions)

Entity Fund Balances: 1997	Obligated	Unobligated Available	Unobligated Restricted	Total
Trust Funds.....				
HI Trust Fund Balance	$ (614)			$ (614)
SMI Trust Fund Balance	752			752
Revolving Funds.....				
HMO Loan *(1)*		$ 11		11
CLIA *(1)*	8	19		27
Appropriated Funds.....				
Medicaid	13,160			13,160
Payments to the Health Care Trust Funds *(1)*			$ 26	26
Other Fund Types.....				
HCFA Suspense Account *(1)*		4		4
Program Management Reimbursables *(1)*		1		1
Total Entity Fund Balances	**$ 13,306**	**$ 35**	**$ 26**	**$ 13,367**

(1) These fund balances are reported in the Supplementary Information section under the "All Others" column of the Financial Statements by Activity.

The $26 million restricted in Payments to the Health Care Trust Funds represent the remaining balance in the FY 1997 apportionment for the general fund's share of the Program Management appropriation. Of the $142 million apportioned, $116 million was transferred to the HI Trust Fund.

NOTE 3: 1997 Investments and Interest Receivable (Dollars in Millions)

1997	Maturity Range	Interest Range	Value
HI			
Certificates	June 1998	6 5/8%	$ 1,838
Bonds	June 1998 to		
	June 2011	6 1/4 - 13 3/4%	114,783
Total HI Investments			**116,621**
SMI			
Certificates	June 1998	6 5/8 - 6 3/4%	2,517
Bonds	June 1998 to		
	June 2012	6 1/4 - 8 3/4%	31,947
Total SMI Investments			**34,464**
Total Medicare Trust Fund Investments			**$151,085**
Trust Fund Investment Interest Receivable			
	HI		$ 2,258
	SMI		591
Total Medicare Trust Fund Investment Interest Receivable			**$ 2,849**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Combined Statement of Financial Position. This schedule summarizes the nature and amount of investments in the Medicare trust funds. See Statement of Accounts for HI and SMI Trust Fund Investments in the Supplementary Information section for a detailed description of the holdings.

The total Medicare interest receivable of $2,849 million is reported to HCFA by the U.S. Treasury and reflects the interest due the trust funds as of September 30, 1997 from the investments listed above.

Note 4: Anticipated Congressional Appropriation

HCFA has recorded an anticipated Congressional appropriation to cover liabilities incurred as of September 30 by the Medicaid program and the Payments to the Health Care Trust Funds appropriation, as discussed below:

Medicaid

Beginning in FY 1996, HCFA has accrued an expense and liability for Medicaid claims IBNR as of September 30. In both FYs 1996 and 1997 the IBNR expense exceeded the available unexpended Medicaid appropriations. HCFA reported the unfunded portion of the IBNR ($5,609 million) as a Future Funding Requirement in FY 1996. At that time, HCFA decided not to record an anticipated Congressional appropriation for the $5,609 million; we believed that such a transaction might have implied an authority to obligate funds which we believed did not exist.

A review of appropriation language by OGC has resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, HCFA has recorded a $957 million anticipated appropriation in FY 1997 and has restated FY 1996 (recording a $5,609 million anticipated appropriation and eliminating the original Future Funding Requirement) for IBNR claims that exceed the available appropriation.

Payments to the Health Care Trust Funds

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums payable "and deposited in the Trust Fund . . . " Section 1844 also outlines the ratio for the match and the method to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year. The appropriated amount is an estimate calculated annually by HCFA's OACT and can be insufficient in any particular fiscal year. In FY 1997 the estimate was insufficient and the matching ceased prior to the close of the fiscal year. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year.

In appropriated entitlement programs like SMI, OMB has stated that budgetary resources cannot be considered available for obligation until Congress has passed an appropriation. Therefore, HCFA has reported the FY 1997 unmatched SMI Federal contribution of $144 million as a liability "not covered by budgetary resources" and as a Future Funding Requirement under the "All Others" column of the Activity Financial Statement.

Nevertheless, HCFA believes that the unmatched Federal contribution has been earned in FY 1997 and has recorded an anticipated appropriation of $144 million. HCFA has also included the $144 million as part of the FY 1997 total $59,615 million Federal Matching Contributions reported as SMI premiums on the Combined Statement of Operations and Changes in Net Position by Activity.

Note 5: Entity Governmental Accounts Receivable (Dollars in Millions)

	Medicare		Total		All	Combined
1997	HI	SMI	Medicare	Medicaid	Others	Total
Medicare Secondary Payer	$ 1,149	$ 766	$ 1,915			$ 1,915
Medicare Provider and Beneficiary Overpayments	2,013	967	2,980			2,980
Civil Monetary Penalties and Other Restitutions	40	197	237		$ 5	242
Managed Care	58	37	95			95
Medicare Premiums	93	188	281			281
Audit Disallowances	2	7	9	$ 32		41
Total Entity Accounts Receivable	**3,355**	**2,162**	**5,517**	**32**	**5**	**5,554**
Less: Allowance for Uncollectible Accounts	1,833	1,236	3,069			3,069
Net Entity Governmental Accounts Receivable	**$ 1,522**	**$ 926**	**$ 2,448**	**$ 32**	**$ 5**	**$ 2,485**

Accounts receivable were primarily obtained from data provided by the Medicare contractors. The majority of these receivables are composed of provider and beneficiary overpayments and those Medicare secondary payer (MSP) claims in which Medicare should have been the secondary rather than the primary payer. Those MSP claims that have been identified to a debtor, and for which a collectible amount has been determined according to HCFA's records, are included in the accounts receivable. An additional 1.4 million claims are being researched as potential MSP accounts receivable and have not been reported due to the uncertain nature of the leads.

The allowance for uncollectible accounts is derived from data based on the last five years of collection experience by type of receivable. No allowance for uncollectible accounts is shown for the Medicaid accounts receivable. The Medicaid accounts receivable has been recorded at a net realizable value, based on an historic analysis of actual recoveries and the rate of disallowances found in the favor of the States. Such disallowances are not considered bad debts; the States elect to retain the funds until final resolution.

Note 6: Non-Entity Governmental Accounts Receivable (Dollars in Millions)

1997	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Medicare Secondary Payer					$442	$ 442
Medicare Provider and Beneficiary Overpayments					84	84
Civil Monetary Penalties and Other Restitutions					1	1
Total Non-Entity Governmental Accounts Receivable					**527**	**527**
Less: Allowance for Uncollectible Accounts					450	450
Net Non-Entity Governmental Accounts Receivable					**$ 77**	**$ 77**

The accounts receivable were primarily obtained from data provided by the Medicare contractors. These receivables reflect the amount of interest owed to HCFA as a result of uncollected provider and beneficiary overpayments, Civil Monetary Penalties, and MSP claims in which Medicare should have been the secondary rather than the primary payer.

The allowance for uncollectible accounts is derived from data based on the last five years of collection experience by type of receivable. The allowance has been adjusted for those contractors that did not report an allowance based on their historical collection experience.

Note 7: Other Liabilities (Dollars in Millions)

1997	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Other Liabilities Covered by Budgetary Resources						
Intragovernmental:						
Uncollected Revenue due Treasury	$ 44	$ 72	$ 116		$ 77	$ 193
Total Other Intragovernmental Liabilities	**$ 44**	**$ 72**	**$ 116**		**$ 77**	**$ 193**
Governmental:						
Medicare Benefits Payable *(1)*	$16,892	$10,498	$ 27,390			$ 27,390
Premiums Billed/Not Yet Due and Unearned Advances *(2)*	39	104	143			143
Demonstration Projects and HMO Benefits	23	5	28			28
Medicaid Benefits Payable *(3)*				$14,035		14,035
Medicaid Audit/Program Disallowances *(4)*				110		110
Total Other Governmental Liabilities Covered by Budgetary Resources	**$16,954**	**$10,607**	**$27,561**	**$14,145**		**$ 41,706**

(1) The Medicare benefits payable of $27,390 million is the estimate by HCFA's OACT of Medicare services incurred but not paid as of September 30, 1997. In FY 1997 HCFA developed a new methodology to estimate this payable. The estimate is based on historical

trends of completeness that take into consideration estimated deductible and coinsurance amounts. The estimate represents (a) claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for 1997 that were paid in 1998, and (e) retroactive settlements of cost reports.

(2) Premiums billed not yet due of $143 million consist of Medicare premiums billed prior to September 30, 1997, but due in FY 1998. In FY 1997 the methodology for determining the deferred credit for Medicare premiums billed was changed.

(3) The Medicaid benefits payable of $14,035 million comprises:

> $11,204 million, which is the net Federal share of expenses that have been incurred by the States but not yet reported to HCFA as of September 30, 1997. The amount reported is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. This information was provided by the States in response to a survey issued by HCFA in November 1997.
>
> $2,831 million, which is the Federal share of expenses that have exceeded advances drawn by the States.

(4) Medicaid audit and program disallowances of $110 million are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to HCFA. HCFA will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay about 26.5 percent of total contingent liabilities. Therefore, of the total contingent liabilities of $417 million, HCFA expects to pay approximately $110 million.

Appeals at the Office of Hearings

Other liabilities do not include all provider cost reports under appeal at the Office of Hearings (OH). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 1997, there were 9,796 cases under appeal at the OH. A total

of 3,204 of these cases were filed in FY 1997. The OH rendered decisions on 107 cases in FY 1997 while 3,122 additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The Office gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 107 cases that were decided in FY 1997, a reasonable liability estimate cannot be projected for the value of the 9,796 cases remaining on appeal as of September 30, 1997. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

Note 8: Net Position (Dollars in Millions)

BY PROGRAM	Medicare			All	Combined	intra-HCFA	Consolidated
1997	HI	SMI	Medicaid	Others	Total	Transactions	Total
Unexpended Appropriations:							
Unobligated							
Available				$ 28	$ 28		$ 28
Unavailable				170	170	$ (144)	26
Undelivered Orders				11	11		11
Invested Capital	$ 14	$ 24	$ 2		40		40
Cumulative Results of Operations	102,776	26,195		2	128,973		128,973
Future Funding Requirements *(1)*	(9)	(19)	(2)	(144)	(174)	144	(30)
Total	**$102,781**	**$ 26,200**	**$ 0**	**$ 67**	**$129,048**	**$ 0**	**$ 129,048**

BY FUND TYPE	Revolving Funds	Trust Funds	Appropriated Funds	intra-HCFA Transactions	Consolidated Total
Unexpended Appropriations:					
Unobligated					
Available	$ 28				$ 28
Unavailable			$ 170	$ (144)	26
Undelivered Orders	11				11
Invested Capital		$ 38	2		40
Cumulative Results of Operations	2	128,971			128,973
Future Funding Requirements *(1)*		(28)	(146)	144	(30)
Total	**$ 41**	**$128,981**	**$ 26**	**$ 0**	**$ 129,048**

(1) Future funding will be required to pay the accrual for annual leave that has been allocated to the Medicare trust funds and Medicaid, and for current year Federal Employees' Compensation Benefit expenses.

Note 9: Employment Tax Revenue (Dollars in Millions)

In calendar year 1997, all employees and employers were each required to contribute 1.45 percent of employees' wages, with no limitation, to the HI Trust Fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration's (SSA) records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting an interim certification of regular wages.

Employment tax revenues are adjusted by excess contributions collected that are refunded to employees. In FY 1997, the HI Trust Fund received a recoupment of $2.9 million to adjust for excess contributions that had been refunded in prior years.

Note 10: SMI Premiums Collected and Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $42.50 beginning January 1996; and $43.80 beginning January 1997. Premiums collected from beneficiaries totaled $19.1 billion in FY 1997 and were matched by a $59.6 billion contribution from the Federal government.

The amount of the appropriation is based on an estimate calculated annually by HCFA's OACT and can be insufficient in any particular fiscal year. In FY 1997, the appropriation was insufficient to match all premiums collected. As such, the matching ceased prior to the close of the fiscal year. In cases like this, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following fiscal year.

For FY 1997, a Future Funding Requirement for $144 million has been recognized for the unmatched SMI premiums under the "All Others" column on the Financial Statements by Activity. Such treatment is consistent with OMB guidance for reporting entitlement programs, which states that funds depending on an appropriation cannot be considered to be covered by budgetary resources until an appropriation has been approved by the Congress.

Note 11: 1997 Other Revenues and Financing Sources (Dollars in Millions)

1997	Medicare HI	Medicare SMI	Total Medicare	All Others	Combined Total
Premiums-Uninsured Individuals	$ 1,279		$ 1,279		$ 1,279
Fraud and Abuse Appropriation	47		47		47
Transfer-Uninsured Coverage	481		481		481
Program Management Admin. Expense *(1)*	116		116		116
Military Service Contribution	69		69		69
Income Tax OASDI Benefits	3,558		3,558		3,558
Railroad Retirement Principal	380		380		380
Civil/Criminal Fines and Penalties	136		136		136
Gifts and Miscellaneous	(17)	$ 1	(16)		(16)
Interagency Agreements Interagency Agreements	1		1	$ 5	6
CLIA and Other User Fees				30	30
Interest and Penalties (Non-Fed)				1	1
HMO Loan Principal Repayments *(2)*				2	2
HMO Loan Principal Repayments transferred to the Federal Financing Bank *(2)*				(2)	(2)
Total Other Revenues and Financing Sources	**$ 6,050**	**$ 1**	**$ 6,051**	**$ 36**	**$ 6,087**

(1) During FY 1997, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund $116 million to cover the Medicaid program's share of HCFA's administrative costs.

Funds are obtained from the HI and SMI Trust Funds as cash is needed to pay for Program Management appropriation expenses. During FY 1997, a total of $1,653 million was obtained from the trust funds to cover cash outlays. Of this amount, $1,387 million was needed to pay for expenses incurred against current year obligations and $266 million was needed for expenses incurred against prior year obligations.

(2) The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. These direct loans were sold, with a guarantee, to the Federal Financing Bank (FFB); HCFA used the proceeds as capital for additional direct loans. Currently, HCFA collects principal and interest payments from HMO borrowers and, in turn, pays the FFB.

Note 12: 1997 Expenses by Object Class (Dollars in Millions)

1997	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Program Expenses by Object Class:						
Medicare						
Insurance Claims and Indemnities						
Fee for Service	$ 120,958	$60,784	$181,742			$ 181,742
Managed Care	15,162	10,551	25,713			25,713
Medicaid						
Grants, Subsidies and Contributions				$ 96,556		96,556
Total Program Expenses	**$ 136,120**	**$71,335**	**$207,455**	**$ 96,556**		**$ 304,011**
Operating Expenses by Object Class:						
Administrative						
Personal Services and Benefits	$ 662	$ 555	$ 1,217	$ 19	$ 5	$ 1,241
Contractual Services	565	872	1,437	83	27	1,547
Grants, Subsidies and Contributions	11	24	35	2		37
Travel and Transportation	2	3	5			5
Rental, Communication and Utilities	13	28	41	3		44
Printing and Reproduction	6	12	18	1		19
Supplies and Materials	1	1	2			2
Equipment	1	3	4			4
Total Administrative Expenses	**$ 1,261**	**$ 1,498**	**$ 2,759**	**$ 108**	**$ 32**	**$ 2,899**
Depreciation and Amortization	$ 3	$ 7	$ 10	$ 1		$ 11
Bad Debts and Writeoffs	671	485	1,156			1,156
Medicare Integrity Program	512		512			512
Imputed Cost Subsidies	3	7	10			10
Other Expenses	3	6	9		$ 1	10
Total Expenses by Object Class	**$ 138,573**	**$73,338**	**$211,911**	**$ 96,665**	**$ 33**	**$ 308,609**

Note 13: Medicare Benefit Payments

Medicare Claims Estimated Improper Payments

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing

claims as billed and paying the correct amount for the services rendered. This process has less than a 2 percent error rate. However, the external billing process, i.e., the documentation provided by providers to support their claims, had an 11 percent error rate with a dollar value in the range of $12.1-$28.4 billion with a midpoint of $20.3 billion compared to a 14 percent error rate with a dollar value in the range of $17.8-$28.6 billion ($23.2 billion midpoint) in FY 1996. The majority of the errors fell into four broad categories: lack of medical necessity, insufficient or no documentation, incorrect coding, and noncovered/unallowable services.

Cost Report Settlement Process

The cost report settlement process, valued at $2.4 billion in 1997, represents the value of net outlays to providers based on fiscal intermediary (FI) audits, reviews and settlements of provider cost reports. Specific services provided to Medicare beneficiaries and billed to Medicare are subject to utilization and medical reviews as each claim is filed. All institutional providers are required to file a Medicare cost report. The cost report represents the costs incurred by a facility to provided medical services to patients and is the final claim for payment from Medicare.

HCFA has devised a methodology that subjects **all** cost reports to an automated Uniform Desk Review process. Based on certain criteria, some providers and/or issues are selected for either a focused, field, or onsite audit. Due to budget constraints, a limited number of cost reports are audited in any given year. In FY 1997, a third of these were onsite audits of a sample number of providers who would not ordinarily be subject to audit. These onsite, "cyclical" audits are used to ensure that cost and statistical records support the data shown on the cost report and use an audit program that is customized for the issue being audited. The remaining audits are selected to concentrate audit dollars in areas of risk to the Medicare program and provide a sufficient return for the dollars spent. The current process has a sentinel effect on all providers.

In 1997, more than 33,000 provider cost reports were subject to desk review. Of that total, just over 5,000 provider cost reports were sent for an audit. Dollars disallowed averaged 1.5 percent of costs claimed. This workload consisted of two primary groups, hospitals paid prospective payment system (PPS) rates, with or without provider-based facilities, and facilities paid based on costs incurred.

	FY 1997 Cost Report Summary		
	(dollars in millions)		
	No Audit	Audit	Total
Providers	28,050	5,038	33,088
Costs claimed	$ 38,736	$ 69,220	$ 107,956
Disallowed	$ 719.7	$ 936.9	$ 1,656.6
per cent	1.9%	1.4%	1.5%

	PPS Single Hospitals		
	(dollars in millions)		
	No Audit	Audit	Total
Providers	1,531	650	2,181
Costs claimed	$ 7,011	$ 7,641	$ 14,652
Disallowed	$ 21	$ 67	$ 88
per cent	0.3%	0.9%	0.6%
	PPS Multi-Facility Hospitals		
	(dollars in millions)		
	No Audit	Audit	Total
Providers	1989	1702	3691
Costs claimed	$ 15,952	$ 55,269	$ 71,221
Disallowed	$ 125.9	$ 513.9	$ 639.8
per cent	0.8%	0.9%	0.9%

Most hospitals are paid PPS rates. The PPS multi-facilities hospitals are hospitals with provider-based home health agencies, outpatient clinics, SNFs, and/or other provider-based facilities. Although the hospital is paid PPS rates, most provider-based facilities are paid on a cost basis. The cost reports are used both to validate the PPS rates and to ensure that areas paid on a cost basis are properly reimbursed. The disallowance rate for these audits in 1997 was low, less than 1 per cent.

The balance of the audits have a higher disallowance rate because they can be targeted toward provider cost reports (like SNFs, HHAs) or areas on the cost report that have the highest risk to the Medicare program.

Dollars disallowed for all non-PPS facilities that were audited in FY 1997 averaged 5.6 percent, versus 3.6 percent if they were subject to only a desk review. The 5.6 percent disallowance rate may represent an upper limit of possible disallowances if all non-PPS cost reports were subject to audit. However, since cost reports are selected for an audit only if there is a significant potential for disallowance, it does not appear to be cost beneficial to expand the number audited to all cost reports.

	Skilled Nursing Facilities		
	(dollars in millions)		
	No Audit	Audit	Total
Providers	10,152	1,181	11,333
Costs claimed	$ 5,553	$ 1,407	$ 6,960
Disallowed	$ 160	$ 92	$ 252
per cent	2.9%	6.5%	3.6%
	Home Health Agencies		
	(dollars in millions)		
	No Audit	Audit	Total
Providers	5,889	720	6,609
Costs claimed	$ 8,118	$ 3,246	$11,364
Disallowed	$ 365	$ 190	$ 555
per cent	4.5%	5.8%	4.9%
	All Non-PPS Facilities		
	(dollars in millions)		
	No Audit	Audit	Total
Providers	24,530	2,686	27,216
Costs claimed	15,773	6,310	22,083
Disallowed	573	356	929
per cent	3.6%	5.6%	4.2%

Note 14: Administrative Expenses (Dollars in Millions)

MEDICARE

	1997
Hospital Insurance	
Treasury	$ 42
Social Security Administration (SSA)	530
Health Care Financing Administration	512
Office of the Secretary - HHS	8
Payment Assessment Commission	3
Peer Review Organizations	166
Total HI Administrative Expenses	**$ 1,261**
Supplementary Medical Insurance	
Social Security Administration	$ 372
Health Care Financing Administration	1,093
Office of the Secretary - HHS	6
Payment Assessment Com./SSA Construction	1
Physicians Payment Review Commission	3
Railroad Retirement Board	5
Peer Review Organizations	18
Total SMI Administrative Expenses	**$ 1,498**
Total Medicare Trust Fund Administrative Expenses	**$ 2,759**
Medicaid	
Health Care Financing Administration	**$ 108**
All Others	**32**
Total Administrative Expenses	**$ 2,899**

For purposes of financial statement presentation, administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, SSA reported $49.5 million of Property and Equipment, (Net) attributable to the Medicare program as of September 30, 1997. This amount is not included in HCFA's Combined Statement of Financial Position as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 1997 to pay for this activity are included in this section as an

administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by Treasury. These expenses are also reported by SSA on their FY 1997 Annual Financial Statement.

HCFA's administrative costs have been allocated to the Medicare and Medicaid programs based on the HCFA cost allocation system. Administrative costs allocated to the Medicare program include $1.2 billion paid to Medicare contractors to carry out their responsibilities as HCFA's agents in the administration of the Medicare program.

Note 15: 1997 Prior Period Adjustment (Dollars in Millions)

1997	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Net Position, Beginning Balance, as Previously Stated	$96,101	$25,798	$121,899	($5,608)	$9,074	$125,365
Restatement of FY 1996 Medicare Payable *(1)*	17,025	(7,387)	9,638			9,638
FY 1996 Medicaid Indefinite Authority *(2)*				5,609		5,609
Total Prior Period Adjustments	$ 17,025	$ (7,387)	$ 9,638	$ 5,609		$ 15,247
Net Position, Beginning Balance as Restated	113,126	18,411	131,537	1	9,074	140,612
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	(10,345)	7,789	(2,556)	(5)	3	(2,558)
Plus (Minus) Non-Operating Changes				4	(9,010)	(9,006)
Net Position, Ending Balance	$ 102,781	$ 26,200	$ 128,981	$ 0	$ 67	$ 129,048

(1) HCFA initiated a corrective action plan to address the concerns raised by the OIG in prior fiscal year audits. One concern was HCFA's method of estimating a liability for unpaid HI and SMI benefit claims as of September 30. In FY 1997, HCFA's OACT developed a new methodology to estimate the liability; HCFA believes the methodology is reasonable and more appropriate for financial reporting. The OACT also revised the liability originally reported in FY 1996. The effects on FY 1997's Net Position for HI and SMI are shown above.

(2) In FY 1996, HCFA reported an unfunded liability of $5,609 million for Medicaid claims IBNR as of September 30, 1997. As a result of a review of the appropriation language by the OGC, HCFA has restated the FY 1996 financial statements to reflect the full funding of the IBNR liability. The prior period adjustment of $5,609 million restores the full funding to the FY 1996 Medicaid Net Position.

Note 16: 1997 Non-Operating Changes (Dollars in Millions)

1997	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Current Year Warrants/ Anticipated Appropriations Exceeding Appropriated Capital Used				$ 4		$ 4
Cancelled Year Funds *(1)*					$ (9,010)	(9,010)
Total Non-Operating Changes				**$ 4**	**$ (9,010)**	**$ (9,006)**

(1) The unexpended appropriations of prior fiscal years in Payments to the Health Care Trust Funds were transferred back to the Treasury.

Supplementary Information

Chapter 3

CONSOLIDATING STATEMENT OF FINANCIAL POSITION BY ACTIVITY
AS OF SEPTEMBER 30, 1997

(Dollars in Millions)

	Medicare HI	Medicare SMI	Medicaid	All Others	Combined	Intra-HCFA Transactions	Consolidate
ASSETS							
Entity Assets:							
Intragovernmental Assets:							
Fund Balance with Treasury	$ (614)	$ 752	$ 13,160	$ 69	$ 13,367		$ 13,367
Investments	116,621	34,464			151,085		151,085
Anticipated Congressional Appropriation			957	144	1,101		1,101
Anticipated Congressional Appropriation for Federal Matching Contribution		144			144	$ (144)	
Accounts Receivable	1	3			4		4
Trust Fund Investment Interest Receivable	2,258	591			2,849		2,849
Governmental Assets:							
Accounts Receivable, Net	1,522	926	32	5	2,485		2,485
Advances and Prepayments	4	6		2	12		12
Restricted Cash	6	39			45		45
Property and Equipment, Net	14	24	2		40		40
Total Entity Assets	119,812	36,949	14,151	220	171,132	(144)	170,988
Non-Entity Assets:							
Governmental Assets: Accounts Receivable, Net				77	77		77
Total Non-Entity Assets				77	77		77
Total Assets	**$ 119,812**	**$ 36,949**	**$ 14,151**	**$ 297**	**$ 171,209**	**$ (144)**	**$ 171,065**
LIABILITIES							
Liabilities Covered by Budgetary Resources:							
Intragovernmental Liabilities:							
Accounts Payable	$ 3	$ 7			10		$ 10
Liabilities for Loan Guarantees				$ 5	5		5
Uncollected Revenue due Treasury	44	72		77	193		193
Governmental Liabilities:							0
Accounts Payable	16	35	$ 3		54		54
Suspense Account Deposit Fund				4	4		4
Accrued Payroll and Benefits	5	9	1		15		15
Other Governmental Liabilities	16,954	10,607	14,145		41,706		41,706
Total Liabilities Covered by Budgetary Resources	17,022	10,730	14,149	86	41,987		41,987
Liabilities Not Covered by Budgetary Resources:							0
Intragovernmental Liabilities:							0
Liability for Unmatched SMI Premiums				144	144	(144)	0
Accounts Payable	2	5			7		7
Governmental Liabilities:							0
Accrued Leave	7	14	2		23		23
Total Liabilities Not Covered by Budgetary Resources	9	19	2	144	174	(144)	30
Total Liabilities	**$ 17,031**	**$ 10,749**	**$ 14,151**	**$ 230**	**$ 42,161**	**$ (144)**	**$ 42,017**
NET POSITION							
Balances:							
Unexpended Appropriations				$ 209	209	$ (144)	65
Invested Capital	$ 14	$ 24	$ 2		40		40
Cumulative Results of Operations	102,776	26,195		2	128,973		128,973
Future Funding Requirements	(9)	(19)	(2)	(144)	(174)	144	(30)
Total Net Position	**$ 102,781**	**$ 26,200**	**$ 0**	**$ 67**	**$ 129,048**	**$ 0**	**$ 129,048**
Total Liabilities and Net Position	**$ 119,812**	**$ 36,949**	**$ 14,151**	**$ 297**	**$ 171,209**	**$ (144)**	**$ 171,065**

COMBINING STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION BY ACTIVITY
FOR THE PERIOD ENDING SEPTEMBER 30, 1997

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
REVENUES AND FINANCING SOURCES						
Direct Appropriations Expended				$ 96,556		$ 96,556
Employment Tax Revenue	$ 112,742		$ 112,742			112,742
SMI Premiums		$ 19,141	19,141			19,141
Federal Matching Contributions		59,615	59,615			59,615
Trust Fund Investment Interest	9,558	2,342	11,900			11,900
Finance Imputed for Cost Subsidies	3	7	10			10
Other Revenues and Financing Sources	6,050	1	6,051		$ 36	6,087
Trust Fund Draws	495	1,054	1,549	104		1,653
Revenue Transferred to Program Management	(620)	(1,033)	(1,653)			(1,653)
Total Revenues and Financing Sources	**128,228**	**81,127**	**209,355**	**96,660**	**36**	**306,051**
EXPENSES						
Program or Operating Expenses						
Medicare Benefit Payments	136,120	71,335	207,455			207,455
(Includes estimated improper payments of $12.1-$28.4 billion)						
Medicaid Benefit Payments				96,556		96,556
Medicare Integrity Program	512		512			512
Administrative Expenses	1,261	1,498	2,759	108	32	2,899
Depreciation and Amortization	3	7	10	1		11
Bad Debts and Writeoffs	671	485	1,156			1,156
Imputed Cost Subsidies	3	7	10			10
Other Expenses	3	6	9		1	10
Total Expenses	138,573	73,338	211,911	96,665	33	308,609
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	$ (10,345)	$ 7,789	$ (2,556)	$ (5)	$ 3	$ (2,558)
Net Position, Beginning Balance, as Previously Stated	96,101	25,798	121,899	(5,608)	9,074	125,365
Plus (Minus) Prior Period Adjustment	17,025	(7,387)	9,638	5,609		15,247
Net Position, Beginning Balance as Restated	113,126	18,411	131,537	1	9,074	140,612
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	(10,345)	7,789	(2,556)	(5)	3	(2,558)
Plus (Minus) Non-Operating Changes				4	(9,010)	(9,006)
Net Position, Ending Balance	$ 102,781	$ 26,200	$ 128,981	$ 0	$ 67	$ 129,048

HOSPITAL INSURANCE TRUST FUND PROJECTIONS

(in billions)

Fiscal Year	Total Income	Total Expenditures	Change in Fund	Fund at Year End	Assets to Expenditures[1] (percent)
1997	$130.2	$139.5	-$9.3	$115.4	90
1998	135.9	143.6	-7.7	107.9	81
1999	140.4	147.2	-6.8	101.1	73
2000	145.0	149.5	-4.4	96.7	68
2001	150.6	153.8	-3.2	93.5	63
2002	156.5	160.6	-4.1	89.4	58
2003	163.1	170.1	-7.0	82.4	53
2004	170.2	180.9	-10.6	71.8	46
2005	178.1	193.3	-15.2	56.6	37
2006	186.0	206.7	-20.7	35.9	27
2007	194.8	221.2	-26.3	9.5	16

[1] Ratio of assets in the fund at the beginning of the year to expenditures during the year.

Note: Totals do not necessarily equal the sums of rounded components.

Reflects intermediate assumptions of the 1998Annual Report of the Trustees of the HI Trust fund.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND PROJECTIONS

(in billions)

Calendar Year	Total Income	Total Disbursements	Net Increase in Fund	Fund at Year End
1997	$81.9	$74.1	$7.8	$36.1
1998	80.6	82.6	-2.0	34.2
1999	88.1	88.4	-0.3	33.9
2000	97.5	97.5	0.0	34.0
2001	107.6	107.3	0.3	34.2
2002	118.6	118.0	0.6	34.8
2003	131.3	129.9	1.4	36.3
2004	143.3	142.4	0.9	37.2
2005	156.3	155.4	0.9	38.1
2006	173.3	169.3	4.0	42.1
2007	190.9	185.6	5.3	47.4

Reflects intermediate assumptions of the 1998 Annual Report of the Trustees of the SMI Trust fund.

Federal Managers' Financial Integrity Act

Material Weakness *1. Financial Reporting - to properly account for Medicare Accounts Receivable and other financial information* - The Medicare contractors are limited in their financial reporting because the systems for claims processing, their primary business function, were not designed to provide the financial data that HCFA needs, and, in most cases, lack general ledgers that incorporate double-entry bookkeeping. To compensate, HCFA designed subsidiary financial reports to enable contractors to report using their existing systems. The OIG subsequently found that, contrary to HCFA instructions, many contractors and some regions were not reconciling the data they reported with existing information. The existing reports were not designed to include all categories of receivables and there is a time difference between when the receivable is recognized and when it is recorded. Difficulty following the "audit trail" is also partly due to some contractors failing to save the documentation required to support the reports, and, in one case, an inaccurate data base.

The interim strategy has been to focus on improving internal controls to ensure HCFA instructions are followed and all appropriate reconciliations are completed. The longer term strategy involves development of an integrated financial management system, which will begin with a review of the current selected Medicare claims processing/financial systems to identify (1) the changes needed to current financial reporting from those systems and (2) the financial data not incorporated in the current selected systems.

Material Weakness *2. Lack of a national error rate for Medicare claims payments* - HCFA does not have a process in place to measure a national claims payment error rate. With passage of the Chief Financial Officers Act (CFO) of 1990 and the Government Performance and Results Act of 1994, the claims error rate is an important measure of both HCFA's and the public's compliance with laws and regulations. In the 1996 audit of the financial statement, OIG tested whether services were (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with prescribed Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records. Although HCFA had a high accuracy rate in paying claims as submitted, the "look-behind" review of the medical documentation which support the sampled claims found a error rate of between 17 and 28 percent.

In the 1997 intra-agency agreement between the OIG and HCFA, it was agreed that OIG will produce a claims error rate as a result of the audit of the financial statement for fiscal years 1996 and 1997. Beginning October 1, 1998, HCFA will have a process in place to measure the national claims error rate, and this process will be audited by the OIG.

ADMINISTRATIVE FUNDING

HCFA's administrative costs are less than one percent of total expenditures. In the past, HCFA has been placed in a difficult position because the agency's resources have been straight-lined (in constant dollars) while the scope and magnitude of the programs it administers increased. This was caused by the budget scoring rules which totally separated mandatory and discretionary spending, with Medicare and Medicaid benefit dollars being on the mandatory side, while the money used to administer these programs was on the discretionary side. Thus, while the benefit payments were growing, the dollars available to administer them were not. Actions to remedy this situation have resulted in a variety of funding mechanisms. Most of HCFA's claims payment and management oversight operations are funded through an annual appropriation; certain quality control functions, primarily the Peer Review Organizations and the Medicare Integrity Programs, are funded through direct trust fund draws; and numerous other activities are funded through a variety of user fees. In 1997, administrative expenses were $2,899 million.

User fees are currently collected to fund the activities related to the survey and certification of laboratories under CLIA, sales of data from HCFA's numerous data bases, and sales of FOIA material. Unless set by statute, these fees are set to cover the costs of doing business and are reassessed at least every two years. Income received from user fees in 1997 ranged from slightly under $200,000 for FOIA to more than $30 million for CLIA. Beginning in 1998, comparative information developed to enhance beneficiary choices will be disseminated under the Managed Care plus Choice provision. This will be funded from a legislatively mandated user fee collected monthly from each managed care organization.

Statement of Account for HI Trust Fund Investments

U. S. TREASURY SPECIAL ISSUES

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6-5/8% maturing June 30, 1998	$11,256,612,000.00	$9,418,683,000.00	$1,837,929,000.00
Total Certificates of Indebtedness	**$11,256,612,000.00**	**$9,418,683,000.00**	**$1,837,929,000.00**

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-3/4% due June 30, 1999	$850,544,000.00	$0.00	$850,544,000.00
13-3/4% due June 30, 1998	262,134,000.00	0.00	262,134,000.00
10-3/4% due June 30, 1998	588,410,000.00	49,294,000.00	539,116,000.00
10-3/8% due June 30, 2000	1,277,566,000.00	0.00	1,277,566,000.00
10-3/8% due June 30, 1999	427,022,000.00	0.00	427,022,000.00
10-3/8% due June 30, 1998	427,022,000.00	427,022,000.00	0.00
9-1/4% due June 30, 2003	4,229,944,000.00	0.00	4,229,944,000.00
9-1/4% due June 30, 2002	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2001	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2000	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1999	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1998	1,034,541,000.00	1,034,541,000.00	0.00
8-3/4% due June 30, 2005	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2004	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2003	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2002	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2001	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2000	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 1999	2,185,751,000.00	0.00	2,185,751,000.00
8-5/8% due June 30, 2002	3,195,402,000.00	0.00	3,195,402,000.00
8-5/8% due June 30, 2001	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 2000	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1999	686,250,000.00	0.00	686,250,000.00
8-3/8% due June 30, 2001	2,509,152,000.00	0.00	2,509,152,000.00
8-3/8% due June 30, 2000	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1999	1,231,586,000.00	0.00	1,231,586,000.00
8-1/8% due June 30, 2006	7,316,968,000.00	0.00	7,316,968,000.00
8-1/8% due June 30, 2005	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2004	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2003	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2002	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2001	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2000	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 1999	901,274,000.00	0.00	901,274,000.00
7-3/8% due June 30, 2007	8,184,929,000.00	0.00	8,184,929,000.00
7-3/8% due June 30, 2006	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2005	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2004	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2003	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2002	867,960,000.00	0.00	867,960,000.00

Continued

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-3/8% due June 30, 2001	$867,960,000.00	$0.00	$867,960,000.00
7-3/8% due June 30, 2000	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1999	867,961,000.00	0.00	867,961,000.00
7-1/4% due June 30, 2009	8,773,256,000.00	0.00	8,773,256,000.00
7-1/4% due June 30, 2008	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2007	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2006	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2005	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2004	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2003	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2002	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2001	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2000	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 1999	225,129,000.00	0.00	225,129,000.00
7% due June 30, 2011	3,368,466,000.00	0.00	3,368,466,000.00
6-7/8% due June 30, 2011	2,166,172,000.00	0.00	2,166,172,000.00
6-1/2% due June 30, 2010	9,037,246,000.00	0.00	9,037,246,000.00
6-1/2% due June 30, 2009	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2008	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2007	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2006	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2005	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2004	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2003	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2002	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2001	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2000	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 1999	263,990,000.00	0.00	263,990,000.00
6-1/4% due June 30, 2008	8,548,126,000.00	0.00	8,548,126,000.00
6-1/4% due June 30, 2007	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 2006	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2005	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2004	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2003	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2002	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2001	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2000	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1999	363,197,000.00	0.00	363,197,000.00
Total Bonds	**$116,293,697,000.00**	**$1,510,857,000.00**	**$114,782,840,000.00**
Total Treasury Special Issues	**$127,550,309,000.00**	**$10,929,540,000.00**	**$116,620,769,000.00**

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1997

U. S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6-3/4% maturing June 30, 1998	$7,045,297,000.00	$6,166,163,000.00	$879,134,000.00
6-5/8% maturing June 30, 1998	7,087,218,000.00	5,449,296,000.00	1,637,922,000.00
Total Certificates of Indebtednes	**$14,132,515,000.00**	**$11,615,459,000.00**	**$2,517,056,000.00**

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
8-3/4% due June 30, 2005	$991,433,000.00	$0.00	$991,433,000.00
8-3/4% due June 30, 2004	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2003	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2002	991,433,000.00	199,508,000.00	791,925,000.00
8-1/8% due June 30, 2006	1,218,813,000.00	0.00	1,218,813,000.00
8-1/8% due June 30, 2005	227,380,000.00	0.00	227,380,000.00
8-1/8% due June 30, 2004	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2003	227,381,000.00	0.00	227,381,000.00
7-3/8% due June 30, 2007	1,293,107,000.00	0.00	1,293,107,000.00
7-3/8% due June 30, 2006	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2005	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2004	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2003	$74,294,000.00	$0.00	$74,294,000.00
7-1/4% due June 30, 2009	1,570,476,000.00	0.00	1,570,476,000.00
7-1/4% due June 30, 2008	47,113,000.00	0.00	47,113,000.00
7-1/4% due June 30, 2007	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2006	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2005	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2004	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2003	47,112,000.00	0.00	47,112,000.00
7-% due June 30, 2011	1,659,860,000.00	0.00	1,659,860,000.00
7-% due June 30, 2010	1,659,860,000.00	0.00	1,659,860,000.00
7-% due June 30, 2009	89,384,000.00	0.00	89,384,000.00
7-% due June 30, 2008	89,384,000.00	0.00	89,384,000.00
7-% due June 30, 2007	89,384,000.00	0.00	89,384,000.00
7-% due June 30, 2006	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2005	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2004	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2003	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2002	867,936,000.00	0.00	867,936,000.00
7-% due June 30, 2001	1,659,861,000.00	0.00	1,659,861,000.00
7-% due June 30, 2000	1,659,861,000.00	0.00	1,659,861,000.00
7-% due June 30, 1999	1,659,861,000.00	0.00	1,659,861,000.00
7-% due June 30, 1998	1,659,861,000.00	897,106,000.00	762,755,000.00
6-7/8% due June 30, 2012	2,227,470,000.00	0.00	2,227,470,000.00
6-7/8% due June 30, 2011	567,610,000.00	0.00	567,610,000.00

Continued

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6-7/8% due June 30, 2010	$567,610,000.00	0.00	$567,610,000.00
6-7/8% due June 30, 2009	567,610,000.00	0.00	567,610,000.00
6-7/8% due June 30, 2008	567,610,000.00	0.00	567,610,000.00
6-7/8% due June 30, 2007	567,610,000.00	0.00	567,610,000.00
6-7/8% due June 30, 2006	567,609,000.00	$0.00	567,609,000.00
6-7/8% due June 30, 2005	567,609,000.00	0.00	567,609,000.00
6-7/8% due June 30, 2004	567,609,000.00	0.00	567,609,000.00
6-7/8% due June 30, 2003	567,609,000.00	0.00	567,609,000.00
6-7/8% due June 30, 2002	567,609,000.00	0.00	567,609,000.00
6-7/8% due June 30, 2001	567,609,000.00	0.00	567,609,000.00
6-7/8% due June 30, 2000	567,609,000.00	0.00	567,609,000.00
6-7/8% due June 30, 1999	567,609,000.00	0.00	567,609,000.00
6-1/4% due June 30, 2008	1,523,363,000.00	0.00	1,523,363,000.00
6-1/4% due June 30, 2007	230,257,000.00	0.00	230,257,000.00
6-1/4% due June 30, 2006	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2005	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2004	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2003	230,256,000.00	0.00	230,256,000.00
Total Bonds	**$33,043,949,000.00**	**$1,096,614,000.00**	**$31,947,335,000.00**
Total Treasury Special Issues	**$47,176,464,000.00**	**$12,712,073,000.00**	**$34,464,391,000.00**

COMBINING STATEMENT OF FINANCIAL POSITION BY ACTIVITY (Restated)
AS OF SEPTEMBER 30, 1996

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
ASSETS						
Entity Assets:						
Intragovernmental Assets:						
Fund Balance with Treasury	$ (460)	$ (206)	$ (666)	$ 7,500	$ 9,072	$ 15,906
Investments	125,805	27,175	152,980			152,980
Anticipated Congressional Appropriation				5,609		5,609
Accounts Receivable	1	3	4			4
Trust Fund Investment Interest Receivable	2,458	441	2,899			2,899
Governmental Assets:						
Accounts Receivable, Net	1,949	990	2,939	41	6	2,986
Advances and Prepayments	5	4	9	596	3	608
Restricted Cash	14	45	59			59
Property and Equipment, Net	17	30	47	2		49
Total Entity Assets	129,789	28,482	158,271	13,748	9,081	181,100
Non-Entity Assets:						
Governmental Assets:						
Accounts Receivable, Net					265	265
Total Non-Entity Assets					265	265
Total Assets	**$ 129,789**	**$ 28,482**	**$ 158,271**	**$ 13,748**	**$ 9,346**	**$ 181,365**
LIABILITIES						
Liabilities Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable		$ 1	$ 1			$ 1
Liabilities for Loan Guarantees					$ 6	6
Uncollected Revenue due Treasury	35	72	107		265	372
Governmental Liabilities:						
Accounts Payable	1	3	4			4
Suspense Account Deposit Fund					1	1
Accrued Payroll and Benefits	3	8	11	$ 1		12
Other Governmental Liabilities	16,616	9,969	26,585	13,745		40,330
Total Liabilities Covered by Budgetary Resources	16,655	10,053	26,708	13,746	272	40,726
Liabilities Not Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable	2	5	7			7
Governmental Liabilities:						
Accrued Leave	6	13	19	1		20
Total Liabilities Not Covered by Budgetary Resources	8	18	26	1		27
Total Liabilities	**$ 16,663**	**$ 10,071**	**$ 26,734**	**$ 13,747**	**$ 272**	**$ 40,753**
NET POSITION						
Balances:						
Unexpended Appropriations					$ 9,074	$ 9,074
Invested Capital	$ 17	$ 30	$ 47	$ 2		49
Cumulative Results of Operations	113,117	18,399	131,516			131,516
Future Funding Requirements	(8)	(18)	(26)	(1)		(27)
Total Net Position	**$ 113,126**	**$ 18,411**	**$ 131,537**	**$ 1**	**$ 9,074**	**$ 140,612**
Total Liabilities and Net Position	**$ 129,789**	**$ 28,482**	**$ 158,271**	**$ 13,748**	**$ 9,346**	**$ 181,365**

COMBINING STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION BY ACTIVITY **(Restated Position)**
FOR THE YEAR ENDED SEPTEMBER 30, 1996

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
REVENUES AND FINANCING SOURCES						
Direct Appropriations Expended				$ 91,435		$ 91,435
Employment Tax Revenue	$ 106,943		$ 106,943			106,943
SMI Premiums		$ 18,931	18,931			18,931
Federal Matching Contributions		54,735	54,735			54,735
Trust Fund Investment Interest	10,223	1,568	11,791			11,791
Other Revenue and Financing Sources	6,169	4	6,173		$ 36	6,209
Trust Fund Draws	587	1,405	1,992	104		2,096
Revenue Transferred to Program Management	(705)	(1,391)	(2,096)			(2,096)
Total Revenues and Financing Sources	**123,217**	**75,252**	**198,469**	**91,539**	**36**	**290,044**
EXPENSES						
Program or Operating Expenses						
Medicare Benefit Payments	122,164	74,033	196,197			196,197
(Includes estimated improper payments of $17.8-$28.6 billion)						
Medicaid Benefit Payments				91,435		91,435
Medicare Integrity Program	251	190	441			441
Administrative Expenses	1,027	1,572	2,599	102	33	2,734
Depreciation and Amortization	2	3	5			5
Bad Debts and Writeoffs	93	28	121			121
Quinquennial Military Service Credit Adjustment	2,366		2,366			2,366
Other Expenses	1	3	4		1	5
Total Expenses	**125,904**	**75,829**	**201,733**	**91,537**	**34**	**293,304**
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	**$ (2,687)**	**$ (577)**	**$ (3,264)**	**$ 2**	**$ 2**	**$ (3,260)**
Net Position, Beginning Balance, as Previously Stated	115,691	11,441	127,132	15,900	8,025	151,057
Plus (Minus) Prior Period Adjustment	123	7,547	7,670	(12,217)		(4,547)
Net Position, Beginning Balance as Restated	115,814	18,988	134,802	3,683	8,025	146,510
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	(2,687)	(577)	(3,264)	2	2	(3,260)
Plus (Minus) Non-Operating Changes	(1)		(1)	(3,684)	1,047	(2,638)
Net Position, Ending Balance	**$ 113,126**	**$ 18,411**	**$ 131,537**	**$ 1**	**$ 9,074**	**$ 140,612**

Audit Opinion

Chapter 4

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date APR 24 1998

From June Gibbs Brown
Inspector General

Subject Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1997 (CIN: A-17-97-00097)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is our final report entitled *"Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1997."*

In accordance with the Government Management Reform Act, we performed a full-scope audit of the Health Care Financing Administration's (HCFA) financial statements. The objective of the audit was to determine whether (1) HCFA's statement of financial position as of September 30, 1997, and statement of operations and changes in net position for the fiscal year (FY) then ended were fairly presented; (2) HCFA's internal controls provide reasonable assurance that transactions are properly recorded and accounted for to permit the preparation of reliable financial statements; and (3) HCFA has complied with laws and regulations that could have a direct and material effect on the financial statements.

In our opinion, except for the effects of the matters discussed below, HCFA's FY 1997 financial statements present fairly, in all material respects, HCFA's financial position at September 30, 1997, and the results of operations and changes in net position for the year then ended in accordance with the accounting principles described in note 1 to those financial statements.

- ***Medicare/Medicaid accounts receivable.*** Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity and to provide adequate audit trails. As a result, we could not determine if the reported $2.5 billion Medicare accounts receivable balance was fairly presented. In addition, we were unable to perform sufficient procedures to satisfy ourselves as to the reasonableness of the $0.45 billion Medicaid accounts receivable balance.

- ***Cost report settlements.*** Due to the limited scope of contractor audits of provider cost reports, we were unable to determine what adjustments, if any, were necessary to the $2.4 billion in FY 1997 cost settlement payments recorded by HCFA or the potential impact of such adjustments on the approximately $5 billion yearend cost settlement estimate included as a component of the Medicare other governmental liabilities account.

Page 2 - Nancy-Ann Min DeParle

As discussed in our report on internal controls, we estimate that the dollar value of improper Medicare fee-for-service benefit payments made during FY 1997 totaled about $20.3 billion nationwide, or about 11 percent of the $177.4 billion in fee-for-service payments reported by HCFA. The estimated range of the improper payments is $12.1 billion to $28.4 billion, or about 7 percent to 16 percent. Considering the significance of the error rate, we concluded that HCFA's oversight of the Medicare program continues to fall short of providing reasonable assurance of detecting and preventing improper Medicare payments. As such, it constitutes a material internal control weakness.

Our report on internal controls notes three other internal control weaknesses that we consider to be material under standards established by the American Institute of Certified Public Accountants and Office of Management and Budget Bulletin 93-06:

1. Significant improvements are still needed in HCFA's methodology for estimating Medicare accounts payable (account now entitled "Medicare Other Governmental Liabilities") for financial statement reporting purposes.

2. The HCFA does not have an integrated financial reporting system to properly account for Medicare accounts receivable and other financial management and reporting issues.

3. The HCFA central office and HCFA contractors have material internal control weaknesses in electronic data processing controls relating to security access and application development and change controls.

We have incorporated informal comments to the draft report where appropriate. Officials in your office have concurred with our recommendations and are in the process of taking corrective action. We would like to thank you and your staff for their outstanding cooperation and assistance in working with us on these most complex and challenging problems.

We would appreciate your views and information on the status of any action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

To facilitate identification, please refer to Common Identification Number A-17-97-00097 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE HEALTH CARE FINANCING ADMINISTRATION FOR FISCAL YEAR 1997

JUNE GIBBS BROWN
Inspector General

APRIL 1, 1998
A-17-97-00097

INDEPENDENT AUDITOR'S REPORT
INSPECTOR GENERAL'S REPORT ON THE
HEALTH CARE FINANCING ADMINISTRATION'S
FINANCIAL STATEMENTS FOR FISCAL YEAR 1997

To: Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

We have audited the accompanying statement of financial position of the Health Care Financing Administration (HCFA) as of September 30, 1997, and statement of operations and changes in net position for the year then ended. These financial statements are the responsibility of HCFA's management and include the accounts of all funds it administers, including the Medicare hospital insurance trust fund, the Medicare supplementary medical insurance trust fund, and Medicaid grants. Our responsibility is to express an opinion on these financial statements based on our audit.

Except as discussed in the following paragraphs, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 93-06, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

Medicare/Medicaid Accounts Receivable. Medicare accounts receivable are stated at $2.5 billion, net of the allowance for uncollectible accounts, at September 30, 1997. Such accounts receivable represent amounts providers owe to HCFA due to overpayments reported by Medicare contractors. Some of the contractors visited were unable to provide subsidiary ledgers and other documentation to support reported accounts receivable activity or to reconcile subsidiary records to amounts reported to HCFA. It was not practical to extend our procedures to enable us to conclude on the Medicare accounts receivable balance or related activity. In addition, estimates of Medicaid accounts receivable, stated at approximately $450 million and netted against the Federal share of Medicaid accounts payable, were developed through a survey process using unaudited information provided by States to HCFA. Such estimates varied significantly by State and by month and were generally not provided at September 30, 1997, but rather were based on earlier reporting dates. Without consistently prepared survey responses and

trend data to analyze the reasonableness of such estimates, it was not practical to extend our auditing procedures to enable us to conclude on the adequacy of Medicaid estimates.

Cost Report Settlements. Medicare Part A providers are paid interim amounts throughout the year and then file a cost report to reconcile actual costs to the interim payments received. In addition to processing and reporting cost settlements made during the fiscal year (FY), HCFA must develop an estimate for cost reports that have not yet been settled at yearend. Typically these payments will not be settled for up to 2 years. Although HCFA has a cost report process, because of limited resources, the provider audit activity is limited to specific issue areas or cost report line items and covers only a limited number of providers. Due to the limited scope of the contractors' provider audit function, there is little assurance that amounts eventually paid to providers through the final cost report settlement process meet Medicare guidelines for reasonableness and appropriateness. We were unable to extend our procedures to determine what adjustments, if any, were necessary to the FY 1997 cost settlement payments of $2.4 billion recorded by HCFA or to determine the potential impact of such adjustments on the approximately $5 billion yearend cost settlement estimate included as a component of the Medicare other governmental liabilities.

As discussed in note 13, HCFA has devised a methodology that subjects all cost reports to an automated uniform desk review process. Based on certain criteria, some providers and/or issues are selected for focused, field, or onsite audits. Due to budget constraints, a limited number of cost reports are audited in any given year. About one-third of these are onsite audits of a sample number of providers that would not ordinarily be subject to audit. These onsite, "cyclical" audits are used to ensure that cost and statistical records support the data shown on the cost report and use a customized audit program. The remaining audits are selected to concentrate audit dollars in areas of risk to the Medicare program and to provide sufficient return for the dollars spent.

In 1997, of 35,079 provider cost reports received, 33,000 were subject to desk review. Of that total, just over 5,000 providers were selected for audit. Dollars disallowed averaged 1.5 percent. This workload consisted of two primary groups: (1) hospitals paid based on prospective payment system (PPS) rates and their provider-based facilities and (2) other facilities paid based on costs incurred. The PPS facilities must submit cost reports if they have provider-based home health agencies, outpatient clinics, or other provider-based facilities paid on a cost basis. These cost reports are used both to validate the PPS rates and to ensure that services paid on a cost basis are properly reimbursed. The disallowance rate on these audits was low--less than 1 percent.

The balance of the audits have a higher disallowance rate because they can be targeted toward provider cost reports that have the highest risk to the Medicare program. Dollars disallowed for all non-PPS facilities averaged 4 percent in FY 1997. However, since the uniform desk review does not currently select those cost reports for audit that do not appear to have a significant potential for disallowance, auditing all cost reports does not appear to be cost beneficial.

As described in note 1, HCFA prepared its financial statements in conformity with the hierarchy of accounting principles and standards approved by the Federal Accounting Standards Advisory Board. The hierarchy is a comprehensive basis of accounting other than generally accepted accounting principles.

In our opinion, except for the effects on the financial statements of adjustments, if any, related to the amounts recorded for Medicare/Medicaid accounts receivable and cost report settlements as a result of the matters noted above, the accompanying financial statements present fairly, in all material respects, HCFA's financial position at September 30, 1997, and the results of operations and changes to net position for the year then ended in accordance with the accounting principles described in note 1 to those financial statements.

Our audit was conducted for the purpose of forming an opinion on the statement of financial position as of September 30, 1997, and related statement of operations and changes in net position for the year then ended. The financial information presented in *HCFA's FY 1997 Financial Report*, including the management overview, is supplemental information required by OMB Bulletin 94-01 and is not a required part of the principal financial statements. We assessed whether this information, and the manner of its presentation, is materially inconsistent with the information, and the manner of its presentation, in HCFA's financial statements. This information, which includes trust fund projections, has not been subjected to audit procedures. Accordingly, we express no opinion on it.

Report on Internal Controls

Except for the matters discussed on pages 1 and 2 of our report on the financial statements, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 93-06, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

In planning and performing our audit of HCFA's financial statements as of and for the year ended September 30, 1997, we obtained an understanding of internal controls, except controls relating to performance measurement data, to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and to determine whether the internal controls meet the objectives identified below. Our consideration included obtaining an understanding of the significant internal control policies and procedures; assessing the level of control risk relevant to all significant cycles, classes of transactions, or account balances; and, for those significant control policies and procedures that have been properly designed and placed in operation, performing sufficient tests to assess more fully whether the controls are effective and working as designed to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on internal control. Accordingly, we do not express such an opinion.

Because of inherent limitations in any internal control structure, errors or irregularities may occur without detection. Also, projecting any evaluation of the internal control structure to future periods is subject to the risk that procedures may become inadequate if conditions change or if the effectiveness of the design and operation of policies and procedures deteriorates.

The HCFA management is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, management makes estimates and judgments of the expected benefits and costs of internal control structure policies and procedures. The objectives of an internal control structure are to provide management with reasonable, but not absolute, assurance that:

- Transactions are properly recorded and accounted for to permit the preparation of reliable financial statements and to maintain accountability over assets;
- Funds, property, and other assets are safeguarded against loss from unauthorized use or disposition; and
- Transactions, including those related to obligations and costs, are executed in compliance with laws and regulations that could have a direct and material effect on the principal financial statements and that OMB, HCFA, or we have identified as being significant for which compliance can be objectively measured and evaluated.

Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure, that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial data consistent with management's assertions in the financial statements.

Material weaknesses are reportable conditions in which the design or operation of one or more internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in the financial statements may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

We noted four internal control weaknesses that we consider to be material weaknesses under standards established by the American Institute of Certified Public Accountants and OMB Bulletin 93-06, as well as three reportable conditions:

INTERNAL CONTROL WEAKNESSES

Material Weaknesses

Reportable Conditions

Material weaknesses 2 and 4 were not identified as such by HCFA in the Department of Health and Human Services (HHS) FY 1997 Federal Managers Financial Integrity Act (FMFIA) report. Significant components of each of these material weaknesses were reported in previous Chief Financial Officers (CFO) audit reports and remain uncorrected.

MATERIAL WEAKNESSES

1. Monitoring National Compliance - Medicare Fee-for-Service Error Rate

Our FY 1996 audit of HCFA's financial statements, dated July 17, 1997, disclosed an estimated $23.2 billion in improper payments, or about 14 percent of the total Medicare fee-for-service payments. Considering the significance of the error rate, we concluded that HCFA's oversight of the Medicare program did not provide reasonable assurance of detecting and preventing improper Medicare payments. This constituted a material weakness which required prompt action by HCFA, including the development of a national error rate and increasing its oversight of Medicare expenditures. While HCFA has begun to implement a corrective action plan, it has not had sufficient time to develop its own process for establishing a national error rate or to significantly reduce the amount of improper payments. It was therefore necessary for the Office of Inspector General (OIG) to perform similar sampling of fee-for-service claims in FY 1997.

FY 1997 Medicare Claim Testing Overview

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 8,048 fee-for-service claims processed for payment during FY 1997, we found that 1,907 claims did not comply with Medicare laws and regulations. By projecting these sample results, we estimated that FY 1997 net overpayments totaled about $20.3 billion

nationwide, or about 11 percent of total Medicare fee-for-service benefit payments. The estimated range of the improper payments at the 95 percent confidence level is $12.1 billion to $28.4 billion, or about 7 percent to 16 percent. These improper payments primarily resulted from provider billings for services that were medically unnecessary, insufficiently documented, noncovered, or incorrectly coded. As was the case last year, these improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Specifically, 98 percent of the improper payments in our sample were detected through medical record reviews coordinated by the OIG in conjunction with medical personnel. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claims processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services as billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors discussed on page 9.

While this year's point estimate is $3 billion less than last year's point estimate $23.2 billion, we cannot conclude that the current error rate is statistically different. The difference may be due to sampling variability or HCFA's and the OIG's efforts toward obtaining better documentation. The year's results could differ from last year's because selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

In view of Medicare's 38 million beneficiaries, 853 million claims processed and paid annually, complex reimbursement rules, decentralized operations, and the current estimate of $20.3 billion in improper payments, the Medicare program remains inherently at high risk for payment errors. Therefore, HCFA needs to continue its efforts to reduce improper payments.

Audit Objective

Our primary objective was to determine whether Medicare benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations (CFR) for services that were:

- Furnished by certified Medicare providers to eligible beneficiaries;
- Reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- Medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Audit Methodology

Statistical Selection Method. To accomplish our objective, we used a stratified, multistage sample design. Our sample frame consisted of 220 quarters (55 contractors x 4 quarters). We stratified the contractors into two strata: stratum 1 included the first, second, and third quarters, and stratum 2 included the fourth quarter. Selecting two contractors from the fourth quarter controlled the amount of audit work required to review fourth quarter claims. We did not stratify the contractor quarters for FY 1996. The selection within each stratum was based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used FY 1996 Medicare fee-for-service benefit payments as the selection weighting factors. Ten contractor quarters were selected from stratum 1, and two contractor quarters from stratum 2. The 12 contractor quarters included 11 contractors (1 contractor was included twice). Of the 11 contractors, 5 are both fiscal intermediaries (FI) and carriers; 2 are FIs, carriers, and durable medical equipment regional carriers (DMERC); 2 are FIs; and 2 are carriers. The FIs process payments for hospitals, skilled nursing facilities (SNF), home health agencies (HHA), rural health clinics, hospices, end stage renal disease facilities, and other institutional providers. Carriers process payments for physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers. The DMERCs process all claims from suppliers of durable medical equipment (DME), prosthetics, orthotics, and supplies under the Medicare Part B program except those for items incident to physician services in rural health clinics or included in payments to such providers as hospitals, SNFs, and HHAs. A DMERC's claims processing jurisdiction is based on the beneficiary's State of permanent residence.

The second stage consisted of a random sample of 50 beneficiaries from each contractor quarter stratified into 4 strata by total amount of payments for services. The random sample of 600 beneficiaries produced 8,048 claims valued at $5.4 million for review. To ensure the completeness of the claims data, we reconciled Medicare contractor claims data to the HCFA 1522 Monthly Financial Report for the 12 contractor quarters selected. The HCFA used this report in its preparation of the FY 1997 financial statements.

We used a variable appraisal program to estimate the dollar impact of improper payments in the total population. The population represented $177.4 billion in fee-for-service payments.

Audit Procedures. We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. Specifically, we used medical review personnel from HCFA's Medicare contractors and peer review organizations (PRO) to assess the medical records and to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations.

We contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response from our initial letter, we made numerous follow-up contacts by letter and, in most instances, by telephone calls. At

selected providers, we made onsite visits to collect requested documentation. Throughout the medical review, we coordinated OIG and medical review efforts to ensure consistency and accuracy. Concurrent with the medical review, we made additional detailed claims reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer (MSP)); and
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Results of Review

Our review confirmed prior findings that the Medicare program is inherently vulnerable to incorrect provider billing practices. Through detailed medical and audit reviews of a statistical selection of 600 beneficiaries nationwide with 8,048 fee-for-service claims processed for payment during FY 1997, we found 1,907 claims that did not comply with Medicare laws and regulations. The contractors have disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claims adjudication process.

We estimate that the point estimate dollar value of improper Medicare benefit payments made during FY 1997 was $20.3 billion, or about 11 percent of the $177.4 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is $12.1 billion to $28.4 billion, or about 7 percent to 16 percent. While this year's point estimate is $3 billion less than last year's point estimate $23.2 billion, we cannot conclude that the current error rate is statistically different. The difference may be due to sampling variability or HCFA's and the OIG's efforts toward obtaining better documentation. The year's results could differ from last year's because selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

The following table shows the types of errors and provider claims included in our $20.3 billion improper payment estimate for FY 1997. About 87 percent of these improper payments occurred within the first six provider types highlighted on the following page:

Types of Errors (dollars in millions)

Type of Provider	*Lack of medical necessity*	*Insufficient documentation*	*Incorrect coding*	*Documents not provided due to extenuating circumstances*[1]	*No documentation*	*Non-covered or not allowable*	*All other errors*	*Total*	*Percentage of improper payments*[2]
Physician	$376	$2,415	$1,698	560	$178	$387	$291	$5,905	29.11%
Inpatient PPS	2,319	460	1,001	264		17		4,061	20.02%
HHA	2,484	50				1		2,553	12.59%
Outpatient	435	1,478	8		2	32	2	1,957	9.65%
DME	100	80	218	1,009	498	33	1	1,939	9.56%
Transportation	397	3	8	714	18	2	(1)[3]	1,141	5.63%
Subtotal	$6,111	$4,504	$2,933	$2,547	$696	$472	$293	$17,556	86.56%
SNF	471	145				13		629	3.10%
Hospice	329	154			138			621	3.06%
End Stage Renal Disease		81	4	375				460	2.27%
Inpatient Non-PPS	448							448	2.21%
Laboratory	76	230	23	19	16	45	10	419	2.07%
Ambulatory Surgery	45	89	15					149	.73%
Total	$7,480	$5,203	$2,975	$2,941	$850	$530	$303	$20,282[4]	100.00%
Percentage of Improper Payments	36.88%	25.65%	14.67%	14.50%	4.20%	2.61%	1.49%		

[1] Cases in which the providers were under investigation, and we were prohibited from requesting medical records. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. It should be noted these claims could be valid or erroneous (including fraudulent).

[2] Percentage of the overall estimate of $20.282 billion by the type of claim.

[3] Negative dollars represent claims for which the number of services billed was less than the number of services provided.

[4] The range of improper payments at the 95 percent confidence level is $12.129 billion to $28.434 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all dollars equals the overall estimate of $20.282 billion.

Each dollar estimate in the previous chart was computed using a method similar to that used in projecting the overall dollar error rate. However, the precision of the dollar estimate by specific type of claim and type of error is not sufficient to use for benchmarking purposes. This would have required an expenditure of audit resources outside the scope of a financial statement audit.

As noted in the chart on the following page, a comparison of the FYs 1996 and 1997 sample results demonstrated that over 70 percent of our point estimate of improper payments in both years occurred in four provider types: physician, inpatient prospective payment system, home health agency, and outpatient services. The chart also shows that most of the errors in both years' samples fell into four general categories:

- documentation errors, including insufficient documentation, documents not provided due to extenuating circumstances, and no documentation;
- lack of medical necessity;
- incorrect coding; and
- noncovered/unallowable services.

Comparison of FYs 1996 and 1997 Types of Provider Categories
Highest Estimated Dollars in Improper Payments

		1997		1996	
	Type of Provider	Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total	Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total
1	**Physician**	**$5,905**	**29.11%**	**$5,027**	**21.67%**
	Documentation	3,153	15.55%	2,756	11.88%
	Medically unnecessary/ noncovered	763	3.76%	943	4.07%
	Incorrectly coded	1,698	8.37%	1,070	4.61%
	Remaining errors	291	1.43%	258	1.11%
2	**Inpatient PPS**	**4,061**	**20.02%**	**5,239**	**22.59%**
	Documentation	724	3.57%	1,040	4.49%
	Medically unnecessary/ noncovered	2,336	11.52%	3,301	14.23%
	Incorrectly coded	1,001	4.93%	900	3.88%
	Remaining errors			(2)	-0.01%
3	**Home Health Agency**	**2,553**	**12.59%**	**3,650**	**15.74%**
	Documentation	68	0.34%	1,684	7.26%
	Medically unnecessary/ noncovered	2,485	12.25%	1,935	8.34%
	Remaining errors			31	0.14%
4	**Outpatient**	**1,957**	**9.65%**	**2,810**	**12.12%**
	Documentation	1,480	7.30%	2,286	9.86%
	Medically unnecessary/ noncovered	467	2.30%	441	1.90%
	Incorrectly coded	8	0.04%	1	0.01%
	Remaining errors	2	0.01%	82	0.35%
	Subtotal	**14,476**	**71.37%**	**16,726**	**72.12%**
5	**Other Types of Providers**	**5,806**	**28.63%**	**6,466**	**27.88%**
	Documentation	3,569	17.60%	3,080	13.28%
	Medically unnecessary/ noncovered	1,959	9.66%	3,128	13.49%
	Incorrectly coded	268	1.32%	7	0.03%
	Remaining errors	10	0.05%	251	1.08%
	Total	**$20,282**	**100.00%**	**$23,192**	**100.00%**

Problems with documentation, medical necessity, and coding errors are consistently systemic problems noted in both fiscal years. Details on these matters follow:

☛ **Documentation**

Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. However, documentation problems represented the most pervasive error category in our sample. This was the largest problem noted in our FY 1996 audit as well. Physician and outpatient services accounted for 52 percent of this error category in FY 1997 and 47 percent in FY 1996.

The overall error category of documentation includes three components: (1) insufficient documentation, (2) no documentation due to extenuating circumstances (under investigation), and (3) no documentation provided after repeated attempts. These three components accounted for about $9 billion ($5.203 billion for insufficient documentation, $2.941 billion for documents not provided due to extenuating circumstances, and $850 million for no documentation), or about 44 percent of the $20.3 billion in improper payments.

The no documentation category was $3.250 billion for FY 1996 and $850 million for FY 1997. There was clearly a reduction in this error category due to the OIG and HCFA outreach efforts to inform providers of our FY 1996 audit results and aggressive action to obtain requested medical records. We obtained almost 98 percent of the medical records requested for sample claims for providers that were not under investigation. As a result of last year's audit, HCFA hosted informational meetings with major provider professional organizations representing various physician specialties, the home health care industry, the DME industry, skilled nursing facilities, chiropractors, hospitals, and other providers. The purpose of these meetings was to familiarize the organizations with our findings and to explore opportunities for collaborating on educational efforts. As a result, various organizations agreed to publicize our audit findings and documentation guidelines in newsletters and other materials issued to their members.

As previously indicated, if providers failed to furnish supporting medical records or submitted insufficient records after the initial request, the reviewers generally requested such documentation numerous times before determining the payment to be improper. In addition, we made repeated contacts with certain providers and even visited some to collect the requested documentation.

With respect to the extenuating circumstances component, these are cases in which the providers were under investigation, and we were prohibited from requesting medical records. Specifically, our sample included 151 claims being investigated by the OIG Office of Investigations and 16 claims being investigated by the Medicare contractors' fraud and abuse units. Because we could not test the validity of these claims, we considered them invalid for determining whether total

fee-for-service expenditures were fairly presented. It should be noted that these claims could be valid or erroneous (including fraudulent).

Some examples of documentation problems follow:

- **Physician**. Medicare paid a physician $42 for an office visit made by a beneficiary with back problems. The physician's office submitted a copy of the claim and a copy of the financial ledger but, even after numerous written and telephone requests, did not submit any medical records.

- **Outpatient.** A hospital outpatient department was paid $785 for eight outpatient physical therapy services provided during a 24-day period. The medical records supplied by the hospital contained support for three of the eight visits. The medical reviewers concluded that the payments for the other five physical therapy services were not supported, resulting in a $491 overpayment.

- **DME**. A Medicare contractor paid almost $3,000 to a DME supplier for 4 months' rental of an electric hospital bed with pressure pad, as well as wound care supplies. The DME supplier did not respond to our requests for medical records. We subsequently went to the supplier's address and found that the office had been vacated. Although the building owner stated that the DME supplier had a 3-month lease which was still current, we were not able to contact the lessors. As a result, we referred the supplier to our Office of Investigations and notified the contractor of our actions.

- SNF. A SNF received $1,967 for a beneficiary's 19-day stay for skilled nursing care. However, there was no indication in the nurse's notes or elsewhere in the records that skilled nursing care was provided during the period. Because providers may receive reimbursement for SNF services only if skilled care is provided on a daily basis, the $1,967 payment was denied.

Lack of Medical Necessity

A lack of medical necessity was the second highest error category for both FYs 1996 and 1997. In both years, such errors in inpatient hospital and HHA claims accounted for over 60 percent of this error category (FY 1996 - $5.236 billion of the total $8.529 billion; FY 1997 - $4.803 billion of the total $7.480 billion).

Decisions on medical necessity were made by the contractor or PRO medical staff using Medicare reimbursement rules and regulations. They followed their normal claims review procedures to determine whether the medical records supported the Medicare claims. As illustrated below, the services as billed were often found not medically necessary.

- **Hospital inpatient**. A beneficiary who had suffered a stroke 5 years earlier was admitted to a hospital to increase her strength. Rehabilitation therapies included occupational, physical, and speech therapies, as well as continuation of routine medications. Based on a review of the medical records, the PRO concluded that the documentation did not support the medical necessity for 37 days ($38,672) of inpatient hospital care.

- **HHA**. A $2,915 HHA claim for home care visits, including skilled nursing services, was denied because the skilled services were medically unnecessary. Our interview with the beneficiary determined that he left home daily and therefore did not meet the definition of "homebound" and was not entitled to Medicare coverage of home health services. Also, we did not find a plan of care signed by the physician in the medical documentation for this care.

- Another HHA received payment of $1,484 for home health and skilled services. The medical files did not contain any information supporting that the beneficiary was unable to leave the home without assistance. After reviewing the Medicare homebound criteria, the prescribing physician stated that the beneficiary was not homebound. Therefore, the medical reviewer denied the entire claim.

- **Transportation**. An ambulance service billed $7,844 for transporting a beneficiary from a nursing home to a dialysis center. The medical reviewer determined that the medical diagnosis included in the ambulance claim was not supported by medical records and that the beneficiary could have traveled safely by other means.

- Another ambulance company was paid $190 for transporting a beneficiary for services that were not medically necessary. In this case, the beneficiary was diagnosed with alcohol dependency. Accordingly, the medical reviewer disallowed the entire payment.

- SNF. A SNF was paid $4,742 for 17 days of care that were not medically necessary. According to the medical records provided by the SNF, the patient received only nominal assistance with daily living. Therefore, the medical reviewer determined that the beneficiary's daily therapy in a SNF was not medically justified.

☛ **Incorrect Coding**

Incorrect coding is the third highest error category this year, representing 14.67 percent of the total improper payments. Inpatient PPS and physician provider types accounted for over 90 percent of the coding errors for both FYs 1996 and 1997.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the contractor medical review staff determined that the documentation

submitted by the providers supported a lower reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Some examples of incorrect coding follow:

- **Physician.** A physician was paid $162 for providing critical care, evaluation, and management of an unstable, critically ill patient requiring the constant attendance of the physician in a hospital inpatient setting. According to the medical reviewer, the records submitted by the provider did not support this level of care but rather a noncritical, high-complexity hospital visit valued at $60. This resulted in a $102 overpayment.

- A physician was paid $96 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the carrier's medical review staff determined that the physical examination was not comprehensive, as documented by the provider, and that the provider should have billed a lower level of care. An overpayment of $43 resulted.

- A physician was paid $73 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the carrier's medical review staff determined that the provider's documentation supported a detailed history, detailed exam, and moderate complexity decisionmaking. Because the provider should have billed a lower level of care, a $24 overpayment occurred.

- **Hospital inpatient.** A hospital was paid $22,229 for a surgical procedure based on the principal and secondary diagnosis codes on the claim. In reviewing the medical documentation, the PRO found that the secondary diagnosis code, which indicated complications, was not supported. The PRO's deletion of this code produced a lesser valued diagnosis related group of $10,151, resulting in a $12,078 overpayment.

- **DME.** A Medicare DME supplier was paid $535 for a gel pressure pad for a beneficiary's mattress. Based on the medical records, the medical reviewer concluded that the supplier had actually provided a pressure pad for a wheelchair, which is reimbursed at $123. This error resulted in an overpayment of $412.

☛ **Noncovered or Unallowable Services**

Medicare unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. About 73 percent of the errors in this category are attributable to physician claims.

According to the *1996 Medicare Handbook*, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;
- eye and ear examinations to prescribe or to fit glasses or hearing aids;
- most prescription drugs;
- most routine foot care; and
- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray.

Following are some examples of noncovered or unallowable services identified during our review:

- **Physician.** A physician was paid $114 for a beneficiary's office visit, electrocardiogram, and various other laboratory tests. After reviewing the medical records submitted by the provider, the medical reviewer determined that payment should be denied because the services were performed as part of a routine physical examination, which is not covered by Medicare.

- Another physician was paid $70 for an office visit with complex decisionmaking, as well as three laboratory tests. The medical reviewer concluded that the billed services should be denied because they were actually part of the beneficiary's routine physical examination.

- A podiatrist was paid a total of $57 for two claims for providing routine foot care (clipping of toenails). Medicare pays for routine foot care only under limited circumstances, such as for the treatment of infected nails. The medical reviewer concluded that the care provided was routine preventive care, which is not covered, and the claim was denied.

- **Hospital outpatient.** A physician was paid $58 for services which, according to the medical records, were part of a routine physical examination. As stated above, Medicare does not cover such examinations.

Conclusions and Recommendations

Medicare, like other insurers, makes payments based on a standard claim form. Providers are required to retain supporting documentation and make it available upon request. As with last year's results, the majority of the improper claims in our sample did not contain any visible errors. However, a significant portion of the errors we found were attributable to a lack of or insufficient documentation on the part of providers that claimed payments. We also identified

numerous errors for services that were not medically necessary, upcoded to obtain higher Medicare payment than the appropriate code would permit, or noncovered or unallowable.

We believe that the FY 1997 audit results confirm that unnecessary or improper payments continue to plague the Medicare program. Without prompt and continued effort in monitoring improper payments, these conditions will continue. However, we acknowledge that too little time has elapsed for HCFA to fully implement our prior year's recommendations and to significantly reduce the error rate.

Specifically, we recommended last year that HCFA:

- Develop a system that estimates improper payments objectively and periodically and disclose the range of such payments in its financial statements.
- Develop a national error rate to focus corrective actions and measure performance in reducing improper payments.
- Report the lack of a national error rate process as a material internal control weakness in the HHS FY 1997 FMFIA report.
- Continue to update its systems' capabilities to keep pace with questionable billing practices.
- Develop and implement stronger deterrents to reduce improper Medicare benefit payments.
- Enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare claims.
- Expand payment safeguard activities and, if necessary, seek additional funding.
- Direct contractors to expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation and the penalties for not doing so.
- Ensure that contractors recover improper payments identified in our review.
- Direct that contractors follow up with specific providers identified in our sample to address documentation and medical necessity concerns and to determine whether other systemic problems need to be corrected.
- Direct contractors to make follow-up evaluations of specific procedure codes with high error rates.

The HCFA generally concurred with our past recommendations and has developed a corrective action plan to reduce the Medicare payment error rate to 10 percent by the year 2002. Accordingly, we offer no additional recommendations. Specific corrective actions follow:

- **Increasing the level of claims review.** At the beginning of FY 1998, HCFA required its contractors to make a prepayment review of the documentation supporting physician claims for evaluation and management codes. The contractors were also asked to increase their overall level of claims review (prepay and postpay), including review of supporting documentation. In addition, pilot projects with the PROs are planned to review 1-day hospital stays, short-term hospital readmissions, and other selected provider procedures.

- **Increasing the number of contractor medical directors.** Contractor medical directors play an important role in medical review activities and provider education. To increase medical director full-time equivalents by 15 percent, HCFA provided the FIs $1 million in FY 1998 funding.

- **Improving the use of technology and data.** The HCFA is developing a system architecture that will incorporate technological advances for detecting fraud, waste, and abuse. Currently, all Medicare contractors use software to evaluate provider billing patterns. The HCFA is evaluating the capabilities, strengths, and weaknesses of analytical, off-the-shelf systems currently supporting the contractors' medical review and fraud and abuse activities. The information gathered will be used to assess the adequacy of system capabilities and to fund improvements as necessary.

  In FY 1998, HCFA will continue developing and refining the HCFA Customer Information System (HCIS) which provides rapid access to national provider and beneficiary utilization data. The HCIS, in combination with various other software tools, allows contractors to better focus review activities. Additionally, HCFA continues to contract with Los Alamos National Laboratories for development of sophisticated statistical methods that use the information known about providers and beneficiaries to score associated claims for fraudulent and abusive activities. The ultimate goal is to improve prepayment reviews of claims.

- **Developing and implementing a substantive testing program.** Pursuant to an agreement with the OIG, HCFA will have a program fully operational by October 1, 1998, to conduct the substantive testing portion of the FY 1999 financial statement audit and to produce a Medicare payment error rate. To date, HCFA has been working very closely with the OIG to fully understand the audit protocol and methodology applied during the FY 1997 audit. The HCFA has also contracted with a statistician to document the sampling and other methodologies used by the OIG so that HCFA can replicate OIG's methodology in FY 1999.

2. Medicare Other Governmental Liabilities (i.e., Accounts Payable)

Reported Medicare other governmental liabilities totaled $27.4 billion at September 30, 1997. These liabilities represent the cost of services provided to Medicare beneficiaries but not paid at the end of the fiscal year. The HCFA has made significant improvements in estimating this liability, including the implementation of a revised estimation methodology.

The revised methodology identified the following five major components comprising other governmental liabilities:

- incurred to approved claims,
- approved to paid claims,
- paid to cleared claims,
- cost settlements, and
- periodic interim payments (PIP).

Data reliability concerns were identified in the incurred to approved claims, approved to paid claims, and cost settlement components of the liability estimation process. The extract program for retrieving applicable data used in calculating incurred to approved claims incorrectly summed payments for certain provider types. In addition, some contractors were not able to provide detailed supporting documentation for the approved to paid claims component. Finally, the revised methodology had to be modified to adjust for deficiencies in the data source used to calculate the estimated liability related to the cost settlement component.

The HCFA's review and approval process initially failed to detect the data reliability concerns noted above. It did not ensure that there was adequate supporting documentation for each component, and review and approval of the components were not clearly documented. This process is still evolving.

Recommendations

Management should periodically analyze and review data to assess the reasonableness of their estimate of other governmental liabilities. Specifically, we recommend that HCFA:

- Periodically validate the data base to ensure the existence and completeness of test data.
- Use the results of the detailed claims testing to assess the reasonableness of the estimate for other governmental liabilities.
- Reconcile data obtained from Medicare contractors as part of the quarterly HCFA 1522 reporting process to other HCFA cost settlement data reports.

- Assess the availability of insurance industry and provider data to establish benchmarks and use this information to assess the reasonableness of the estimate for other governmental liabilities.
- Reconcile its estimate to the National Claims History File monthly processing reports.
- Perform a trend analysis of the accounts payable estimate to expenditure history.
- Periodically validate key information, such as data from contractor 750 reports.

3. Financial Management Controls for Contractors and Preparation of HCFA Financial Reports

The OMB Bulletin 94-01 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal controls, and reliable data. However, HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level. Instead, it relies on a complex system of reporting and ad hoc reports to accumulate data for financial reporting. Our review of the internal control structure at selected Medicare contractors disclosed numerous weaknesses in their ability to report accurate financial information. These weaknesses may be partly due to the absence of certain components of a fully integrated financial management system, including full accrual accounting, a double-entry general ledger system, proper cut-off procedures, and adequate source documentation. These weaknesses increase the risk of material misstatement in the financial statements. In addition, contractors do not have uniform accounting systems that record, classify, and summarize information for the preparation of financial statements. Moreover, HCFA's central and regional office oversight of contractor operations and financial management controls has not provided reasonable assurance that material errors would be detected in a timely manner.

3(a) Medicare Accounts Receivable

Medicare accounts receivable represent funds owed by providers to HCFA due to overpayments reported by Medicare contractors. These accounts receivable are stated as $2.5 billion at September 30, 1997, net of the allowance for uncollectible accounts. Medicare contractors were not able to provide sufficient detailed records to support accounts receivable balances reported to HCFA to prepare the yearend financial statements. Many of the deficiencies reported in previous years continued to exist throughout FY 1997, as noted below:

- We could not obtain reasonable assurance of the completeness and support for $266 million in accounts receivable that a contractor reported as transferred to other Medicare FIs during its transition from the Medicare program. In addition, HCFA has been unable to reconcile, through its 750/751 quarterly contractor financial reports, the

$266 million to the acquiring Medicare contractors. Based on our review, procedures were either not established or not followed among HCFA and the Medicare contractors to confirm and reconcile the transferred accounts receivable.

- At 9 of the 11 contractors selected for testing, we were unable to obtain assurance of the completeness of accounts receivable. Specifically, detailed subsidiary ledgers could not support accounts receivable balances and/or adjustments reported to HCFA on the 750/751 reports. For example, one contractor could not provide subsidiary ledgers for $21 million of the $86 million balance reported to HCFA. Another contractor adjusted (plugged) the "reclassified/adjusted" amount by $757,821 to reconcile the ending subsidiary balance to the balances reported on the HCFA 750/751. The contractor was unable to explain the variance.

- One contractor reported a $3 million accounts receivable balance on its MSP tracking report and $5.5 million on its HCFA 750/751 report as of September 30, 1997. Without extensive audit work, we could not determine which amount was correct.

- Three contractors did not record accounts receivable overpayments in a timely manner. One contractor did not record receivables for final settlement until the payment was received, instead of when it was identified. Contractors took over 50 days to record these overpayments as actual receivables.

As a result of these accounts receivable control weaknesses, HCFA may not be collecting millions of dollars in overpayments from providers. These problems have been addressed in HCFA's current corrective action plan.

3(b) Controls Over Cash

We reviewed the contractors' cash procedures to determine whether adequate safeguards and records were in place and whether duties were properly segregated. These controls typically are designed to protect assets against theft, loss, misuse, or unauthorized alteration and to reduce the opportunities for the occurrence and concealment of errors or irregularities. We identified the following weaknesses:

- Seven of 11 contractors reviewed did not maintain general ledgers or subsidiary ledgers supporting cash balances.

- Four contractors did not properly segregate duties in that the same individuals were responsible for receiving and endorsing checks, preparing and recording deposits, and performing bank reconciliations.

- Five contractors did not apply accounts receivable collections in a timely manner.

- Three contractors did not prepare bank reconciliations in a timely manner and, when prepared, the reconciliations were not adequately documented.

- Two contractors left Medicare checks unsecured.

3(c) Financial Reporting and Reconciliations - Medicare Contractors

The reconciliation of "total funds expended" on the HCFA 1522, Monthly Contractor Financial Report, is an important control which ensures that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. The HCFA uses the information from this report in preparing its financial statements.

Our analysis of the HCFA 1522 report at the 11 selected Medicare contractors identified the following internal control weaknesses:

- Paid claim activity and "total funds expended" were not formally reconciled at 7 of the 11 contractors. For example, it took several months for these contractors to produce payment tapes that reconciled with the monthly 1522 reports because adjusting entries were not identified and proper cutoff periods were not used. Improvements were noted at the remaining four contractors due to HCFA/OIG training or prior participation in the FY 1996 CFO audit.

- Several contractors had no internal written policies or procedures for preparing the HCFA 1522.

- In many cases, readily available general ledgers and appropriate subsidiary records were not maintained to support all components of "total funds expended" on the HCFA 1522. For example, to prepare the monthly HCFA 1522 reports, contractors had to obtain data from various sources, such as the computerized claims processing system, bank statements, manually prepared documents and ledgers, and estimates. This data was then manually combined by contractors' accountants into the HCFA reporting formats. However, the source documents were not always maintained or accurate. For example, based on our audit work, three contractors submitted revisions to properly reflect the amounts reported to HCFA on their 1522s.

- Some contractors did not subject the HCFA 1522 to independent verification. For example, one contractor double-counted $55 million of electronic fund transfers for several months. This had a cumulative effect on subsequent monthly 1522s of

overstating the cash on hand and letter of credit draws. This matter was not detected until we brought it to the contractor's attention.

Although we noted similar weaknesses in our prior internal control reports issued to HCFA, contractors have not effectively implemented the controls necessary to ensure adequate financial reporting.

3(d) Financial Reporting - HCFA Central Office

The CFO Act imposes important requirements on all Federal agencies, including HCFA. Many of these requirements center around the development of annual financial statements in accordance with generally accepted accounting principles. Since Federal agency financial statements are prepared only annually, significant accounting issues are not addressed throughout the year. While HCFA, especially the Division of Accounting, is faced with significant staffing constraints, preparing the financial statements once a year taxes the accounting function beyond its capabilities and is at least partially responsible for certain conditions that were noted this year.

The HCFA's process for preparing annual financial statements is manually intensive, involving a series of spreadsheets which start with general ledger data and adjustments to incorporate Treasury information and contractor information which HCFA has determined is needed as the financial reporting process has evolved. While HCFA's FACS is a dual-entry system, extensive adjustments are made outside this internal control system to prepare the annual financial statements. This increases the risk that material errors may not be detected in a timely manner.

Specifically, we found that:

- The HCFA's primary accounting system, FACS, does not capture all financial data reported by HCFA. For example, Treasury data is reported to HCFA outside of FACS and has a significant impact on the financial statements.

- The HCFA does not have formal written policies and procedures for preparing, approving, or retaining journal entries.

- Controls over the safeguarding of financial reporting spreadsheets, including verification of calculations and password protection, were not adequate. In addition, these spreadsheets, which include prior and current period entries, are not posted to the general ledger. For example, the ending balance in net position at September 30, 1996, did not initially roll forward to the beginning balance for the following year.

Recommendations

To improve financial management controls and financial reporting, we recommend that HCFA:

- Review and monitor the accounts receivable internal control structure to provide reasonable assurance that reported amounts are valid and documented.
- Establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information.
- Ensure that all contractors establish a general ledger system that incorporates double-entry bookkeeping.
- Enhance contractor cash controls by emphasizing the importance of segregation of duties, reconciliation processes, and other cash control techniques.
- Ensure that all contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation, and periodically review contractors' control procedures over the reconciliation.
- Ensure that contractors receive ongoing training on HCFA 750/751 reports.
- Develop appropriate input/output controls for routinely reviewing the HCFA 750/751 and other reports received from contractors to identify unusual items and inconsistencies and emphasize HCFA's reliance on these reports.
- Revise reporting requirements to reflect HCFA's expectation and need to retain support, in an auditable format, for significant accounts at each contractor.
- Explore obtaining software to reduce the manual manipulation of data necessary to develop financial statements, and develop procedures to provide an audit trail and approval of entries and assumptions made.
- Include the issues relating to financial management discussed in this report in the HHS FY 1998 FMFIA report.

4. Medicare Electronic Data Processing (EDP) Controls

Numerous EDP control weaknesses, as noted on the following page, were found at the HCFA central office and selected Medicare contractors. Specifically, we found deficiencies in entity-wide security programs, access controls, application development and change controls, segregation of duties, systems software, and service continuity planning at the HCFA central

office and/or multiple contractor sites. Access controls, as well as application controls, are being reported as material weaknesses.

Assessment of HCFA Central Office and Medicare Contractors' General Controls and Application Controls

Audit Areas	HCFA Central Office		Medicare Contractors		
	Reportable Conditions	Material Weakness	Reportable Conditions		Material Weaknesses
General Controls			**OIG**	**SAS 70[1]**	
Entity-wide security	5		15		
Access controls	5	1	31	4	1
Application development and program change controls	3		7	3	
Segregation of duties	1		3		
System software	2		14	1	
Service continuity	1		9	4	
GHP, FACS, EDB, and APPS applications[2]	14				
Application controls					
Specific to Florida shared system(FSS)			2	N/A	2
Specific to MCS			2	N/A	1
Specific to CWF			2	N/A	
Input, processing, and output controls			5	N/A	

[1] Statements on Auditing Standards (SAS) 70 reviews are made by independent public accountants under contract to HCFA.

[2] GHPS is Group Health Plan System, FACS is Financial Accounting Control System, EDB is Enrollment Data Base, and APPS is Automated Payment Plan System.

Background

For FY 1997, HCFA relied on extensive data processing operations at its own offices and at contractors that process and account for $212 billion in Medicare expenditures. The HCFA central office computer center primarily maintains administrative data, such as Medicare enrollment, eligibility, and paid claims data, but it also processes all payments for managed care.

Medicare contractors use one of several "shared" systems to process and pay Medicare fee-for-service claims. The shared systems interface with the Common Working File (CWF) to obtain authorization to pay claims. The CWF uses nine distributed databases to coordinate Medicare Part A and Part B benefits and to approve claims for payment. These databases are maintained by contractors referred to as CWF hosts, while the shared systems and CWF are designed and maintained by separate contractors referred to as systems maintainers.

Our review of EDP internal controls was limited to general and application controls and did not include management or operations controls. Controls associated with the general data processing environment (general controls) are critical to ensuring the reliability, confidentiality, and availability of HCFA data. These EDP general controls involve the entity-wide security program, access controls, application development and change controls, segregation of duties, operating system software, and service continuity. They affect the integrity of all applications operating within a single data processing facility.

HCFA Central Office

The EDP general controls at the HCFA central office continue to be ineffective. Our assessment disclosed a material internal control weakness over access as well as other weaknesses in the five EDP general control areas.

Specifically, we found deficiencies in entity-wide security programs, access controls, application development and change controls, segregation of duties, systems software, and service continuity planning at the HCFA central office and/or multiple contractor sites. Each of these areas merits additional attention. For example, data security remains a major concern at the HCFA central office. Our prior-year review demonstrated weaknesses in EDP general controls through a system penetration test in which we obtained access privileges to read or modify sensitive Medicare enrollment, beneficiary, provider, and payment information. Although HCFA immediately corrected the prior-year vulnerabilities, our current-year tests resulted in penetrating the mainframe data base. We obtained the capability to modify managed care production files.

Furthermore, we found that data center users without specific authorization to the managed care system have the potential to gain update access to those same files. Although HCFA had already made enhancements in this area during FY 1996, additional effort is necessary to fully secure the mainframe data base. Moreover, our system penetration test revealed additional control problems, including the existence of an unknown bulletin board, the presence of various network

vulnerabilities such as open host sites and available services, and the availability of HCFA's network information unblocked and obtainable from HCFA's Internet service provider. These network-related vulnerabilities could be exploited by unauthorized individuals to compromise one or more of HCFA's computer systems. In addition, subsequent to our field work, HCFA initiated an in-depth security self-assessment, including a sophisticated network penetration test disclosing several weaknesses. The HCFA is actively developing an appropriate corrective action plan.

The entity-wide security program should provide a framework for managing risk, developing security policies, assigning responsibility, and monitoring the adequacy of computer-related controls. However, our 1997 work disclosed that HCFA had not performed risk analyses, developed security plans, or ensured that proper corrective action was taken for its general support systems, including the computer center, telecommunications, and networks, and significant applications. As a result, HCFA management has no assurance that cost-effective controls are implemented to manage risks associated with the systems. In addition, the security structure was not adequate to ensure that security program objectives are achieved.

Serious weaknesses in application development and change controls are still outstanding from the FY 1996 audit. The centralized production control group controlled only about 15 percent of the production batch programs. In addition, HCFA did not use its library management software to provide version control over the application source code or ensure that the executable program code was created from the appropriate source code. Because of these weaknesses, HCFA risks implementing unauthorized programs, which could result in improper processing of Medicare claims or eligibility information or allow malicious programming changes that could interrupt data processing or destroy data files and programs.

The HCFA also has not addressed the prior segregation of duties issue. We noted that electronic data processing functions were not adequately separated to prevent one individual from controlling key aspects of computer-related operations.

Controls over operating system software integrity remain ineffective. As noted in our FY 1996 audit, this software was not adequately restricted, and HCFA still allows an excessive number of contractors and systems personnel to have update access to the software. This excessive access increases the risk of accidental corruption of the operating system. In addition, the operating system software parameters could be overridden during system generation or "reboots," which could result in a different mainframe configuration.

Finally, serious weaknesses in service continuity controls have not been resolved. Continuity controls should ensure that critical operations continue without interruption or are promptly resumed and that critical and sensitive data are protected when unexpected events occur. The HCFA has not updated its critical application list in the contingency planning document since 1992. Because several applications have been developed, modified, or combined since then,

HCFA's contingency plan cannot ensure that its critical applications would be promptly restored in the event of a disaster.

Medicare Contractors

The EDP general controls were assessed at 14 Medicare contractors, including 3 systems maintainers and the 6 SAS 70 locations. We concluded that four Medicare contractors and four of the five CWF host sites had effective general controls. However, these locations had significant weaknesses in many of the six areas of general controls. Specifically, we are reporting application change controls to be a material internal control weakness, as discussed below. In addition, although SAS 70 reports do not contain a separate conclusion on EDP controls, five of the six SAS 70 locations had exceptions noted on EDP controls. Further, one Medicare contractor and one CWF host site had ineffective general controls, and two of the three shared systems had ineffective controls.

We noted material control weaknesses related to the FSS (Part A) and MCS (Part B) shared systems. For the FSS, data centers had full access to the source code and could perform local changes to FSS programs. These changes were not subjected to the same controls that exist in the standard FSS change process. Additionally, one data center developed an override library to give priority to locally modified FSS programs. Consequently, the local programs always override the standard FSS programs provided by the maintainer. For the MCS, each individual carrier could deactivate HCFA-mandated edits. The lack of a controlled modification process over the shared systems does not ensure that only authorized programs are implemented and executed by FIs and carriers.

For the entity-wide security program, two reportable conditions were common to most contractors: entity-wide risk assessments were not performed, and organization-wide security plans were not documented. Regarding access controls, we noted one material control weakness related to inadequate physical security at a contractor facility. We were able to enter and exit that facility without proper identification and verification. Also for the access control area, most contractors visited had three reportable conditions: individuals were granted inappropriate access to the data center, dial-up telephone numbers were not periodically changed, and data and resource classifications were not available. Regarding application software development and program change controls, most of the weaknesses related to library management.

For segregation of duties, the common reportable condition was the lack of documented policies and procedures on separation of incompatible duties. For system software, four reportable conditions were common: personnel had inappropriate access to and reporting of sensitive utilities, inappropriate libraries were resident in the authorized program facility, logs or system management facility data sets could be altered by systems personnel, and the systems environment could be reconfigured by computer operators during initial program loads or by "rebooting" the system. Pertaining to service continuity, two contractors did not have a current disaster recovery plan. This issue is critical to the recoverability of Medicare systems.

Further, as evidenced by the varied findings among the Medicare contractors, HCFA does not have a consistent set of policies to oversee and review the effectiveness of general controls at its contractors. As such, HCFA has not adequately monitored these contractors in prior years. However, in response to prior recommendations, in FY 1996 HCFA began a program to contract EDP control assessments at selected contractors.

Conclusion and Recommendations

Medicare relies on automated systems to administer virtually all aspects of the program. However, material weaknesses exist at the HCFA central office system, two of the Medicare contractors, and two of three shared processing systems.

For the central office EDP controls, we recommend that HCFA implement cost-effective improvements to ensure that:

- An entity-wide security structure is developed to achieve security program objectives. Specifically, HCFA should ensure that easily guessed passwords (e.g., system passwords used by installers and passwords related to functions being performed) are not used, enforce periodic password changes, and record and track access to sensitive data with a hard copy report sent to the responsible system manager.
- Access controls are adequate to protect data and other resources from unauthorized modification or destruction.
- Application development and program change control procedures protect against unauthorized changes.
- Assigned responsibilities adequately segregate computer-related duties.
- Controls over system software integrity and changes properly restrict access to authorized personnel and protect against unauthorized changes.
- Service continuity plans are current and periodically tested.
- The material weaknesses associated with the HCFA central office and Medicare contractors are reported in the HHS FY 1998 FMFIA report.
- The periodic evaluation of contractor EDP controls continues, and all findings and recommendations are tracked through final implementation.

For the Medicare contractor EDP controls, we recommend that HCFA coordinate with contractors to ensure that:

- The FSS changes are authorized, documented, and tested to maintain the integrity of the application. Additionally, override libraries should be further examined to determine the necessity of their use.

- Carriers do not modify mandated edits and essential audits in the MCS application, and claims are processed in accordance with existing Medicare regulations.

- An entity-wide security structure is implemented to achieve security program objectives, access controls are adequate to protect data and other resources from unauthorized modification or destruction, application development and program change control procedures protect against unauthorized changes, assigned responsibilities adequately segregate computer-related duties, controls over system software integrity and changes properly restrict access to authorized personnel and protect against unauthorized changes, and service continuity plans are current and periodically tested.

REPORTABLE CONDITIONS

1. HCFA Regional Office Oversight of Medicare

The HCFA regional offices have oversight responsibility for Medicare contractors. A majority of the oversight efforts are conducted under the Contractor Performance Evaluation (CPE) review process. The purpose of CPE is to evaluate Medicare contractors' compliance with contracts, laws, and regulations.

Contractors prepare and submit periodic financial reports to HCFA for use in preparing HCFA's financial statements. However, at the three regional offices we visited, oversight activities were not adequate to ensure that financial data provided by contractors is reliable, accurate, and complete. Specifically, our review identified the following problems:

- Contractors report benefit payments on the HCFA 1521/1522 forms and are responsible for reconciling these amounts to their accounting records. The regional offices do not ensure that the contractors perform this reconciliation and do not verify the validity of the benefit payment data.

- The Audit Quality Review Program, designed to evaluate contractors' performance in the auditing and settlement of Medicare cost reports, is not being applied to enough cost reports to provide adequate assurance of the validity of the total cost settlements.

- On a quarterly basis, contractors are required to submit HCFA 750A/B (Statement of Financial Position) and HCFA 751A/B (Status of Accounts Receivable) to the regional

offices. The regional offices, however, perform either no onsite reviews or very limited reviews of these reports, and the reviews that are conducted do not include testing the validity, accuracy, or completeness of the reported data.

- New regulations effective January 2, 1997, require regional office concurrence before suspending payments to a provider on the basis of fraud or abuse. To properly oversee and ensure that proper sanctions are imposed, the regional offices need accurate data on all contractor referrals of fraud and abuse cases. But the regional offices are not tracking new and pending fraud and abuse cases filed by contractors directly with the OIG.

- The regional offices review the contractor MSP program in accordance with a protocol that meets requirements specified in the regional office manual. However, not all procedures in the protocol are applied to each contractor each year, nor is there a documented risk assessment of contractor MSP operations for deciding which contractors and contractor functions to review.

- Two major on-line reporting systems are used to track the status of Medicare overpayments identified by the contractors. The Provider Overpayment Report (POR) is used by FIs (Part A), and the Physician/Supplier Overpayment Report (PSOR) is used by carriers (Part B). The regional office oversight responsibility includes monitoring and evaluating contractor overpayment identification and collection activities. The regional offices we reviewed did not make any Part A onsite reviews of the accuracy of the contractors' input into the POR system, and the Part B reviews were not adequately documented to support the procedures performed and the findings.

- Contractors are required to submit annual certifications of their internal controls for compliance with certain laws and regulations. However, the regional offices do not evaluate the accuracy and reliability of the documentation supporting the certifications.

- Change management plans (formerly task management plans) are prioritized changes mandated by the HCFA central office to be completed by contractors on a quarterly basis. The majority of these changes involve edit changes to the claims processing systems. A shared system maintainer is responsible for implementing the changes and disseminating information to system users. The regional offices do not make systems tests to ensure that the change management plans are properly and timely implemented.

- Contractors enter cost report settlement data into the System Tracking of Audit and Reimbursement (STAR) report. The regional offices are responsible for monitoring the contractors' timely settlement of cost reports by reviewing the STAR reports. However, the regional offices have not made any recent onsite reviews of the contractors' supporting documentation to verify the accuracy of the data entered into the STAR system.

Recommendations

We recommend that HCFA:

- Increase their oversight of Medicare contractors' financial reporting data.
- Periodically test the validity of submitted financial information and obtain supporting documentation.
- Ensure that the contractors reconcile various financial reports, such as the 750/751 to POR and PSOR and the 1522 to the paid claims file.
- Develop corrective action plans for resolving past as well as current OIG financial statement findings and recommendations and follow up to determine effective implementation.

2. Federal Share of Medicaid Accounts Payable and Accounts Receivable

Federal financial accounting standards require that the Federal portion of Medicaid accounts payable and accounts receivable recorded by the States be recorded in the Medicaid program's financial statements. In an attempt to accumulate this information, HCFA distributed a survey form to the States in 1996 and 1997. Based on the survey results, HCFA estimated the net liability as of the end of each fiscal year and recorded these amounts in the financial statements.

The survey information on the Federal share of accounts receivable received by HCFA was very limited. In addition, most of the information received was as of June 30, 1996 and 1997. Our testing showed that the accounts receivable balances can be fairly volatile from State to State and from month to month within a State. Since HCFA received only limited information and did not receive the information as of the fiscal yearend, accurately estimating the total Federal share of accounts receivable is very difficult.

Recommendation

We recommend that HCFA improve its estimate of the Federal share of Medicaid accounts payable and receivable through the following procedures:

- The HCFA should continue its annual survey but should send the survey well in advance of the due date and include clear, comprehensive instructions.
- Survey responses should be carefully monitored and procedures implemented for second requests, telephone follow-ups, and guidance to State personnel in completing the survey.

- Trend data of accounts receivable and accounts payable over time should be developed for each State and used to improve and further refine the estimation model.

3. HCFA Regional Office Oversight of Medicaid

One of the primary responsibilities of the regional offices is to ensure that the States submit timely, accurate financial reports and comply with various laws and regulations. However, as noted below, many oversight procedures previously performed by the regional offices have been severely reduced or eliminated in recent years:

- The regional offices have reduced their emphasis on reviews of the quarterly HCFA 64 packages and have placed increased reliance on systems and controls verified by other agencies or States and less emphasis on detecting errors and irregularities.

- Effective in June 1996, HCFA eliminated all Federal requirements for using the Claims Processing Assessment System for those States operating on the approved Medicaid Management Information System (MMIS). However, the regional offices have not instituted procedures to determine whether programs developed by the States are sufficient to properly examine and evaluate the accuracy of claims processing.

- Pursuant to section 4753 of the Balanced Budget Act of 1997, HCFA no longer has authority to perform system performance reviews of each State's MMIS.

- The regional offices have been unable to devote sufficient resources to reviewing and reporting on the States' procedures for identifying fraud and abuse and collecting recoveries.

- The regional offices have not been able to review all States for compliance with regulations relating to disproportionate share payments.

Recommendation

We recommend that HCFA review the entire regional office oversight process and develop or reenact policies to provide sufficient oversight of the States' Medicaid claims processing and reporting.

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In addition to the reportable conditions described above, we noted certain matters involving internal control weaknesses which we reported to HCFA management in a separate letter dated March 4, 1998.

Report on Compliance with Laws and Regulations

Except for the matters discussed on pages 1 and 2 of our report on the financial statements, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 93-06, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

The HCFA management is responsible for complying with applicable laws and regulations. As part of obtaining reasonable assurance about whether HCFA's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 93-06, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996. We also obtained an understanding of management's process for evaluating and reporting on internal control and accounting systems as required by the FMFIA and compared the material weaknesses reported in HCFA's FMFIA report that relate to the financial statements under audit with the material weaknesses and other reportable conditions found during our evaluation of HCFA's internal controls. In evaluating HCFA's internal controls and conducting substantive audit procedures, we identified certain reportable conditions that were not included in HCFA's FMFIA report.

Material instances of noncompliance are failures to follow applicable laws and regulations to the extent that the effects of such noncompliance, in the aggregate, cause the financial statements to be misstated. The results of our tests of compliance disclosed a material instance of noncompliance. Specifically, as discussed on page 5 of this report, through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 8,048 fee-for-service claims processed for payment during FY 1997, we found that 1,907 claims did not comply with Medicare laws and regulations. By projecting these sample results, we estimated that FY 1997 net overpayments totaled about $20.3 billion nationwide, or about 11 percent of total Medicare fee-for-service benefit payments. The estimated range of the improper payments at the 95 percent confidence level is $12.1 billion to $28.4 billion, or about 7 percent to 16 percent. The estimated effect of the material Medicare fee-for-service noncompliance has been reflected in HCFA's FY 1997 financial statements.

We performed tests of compliance to determine whether HCFA's financial management systems substantially comply with the Federal financial management systems requirements, applicable accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance using the implementation guidance for FFMIA issued by OMB on September 9, 1997. Our tests of HCFA's Year 2000 planning were limited to obtaining and reading the applicable Year 2000 progress reports submitted to HHS.

An audit of financial statements conducted in accordance with generally accepted auditing standards, *Government Auditing Standards* issued by the Comptroller General of the United States, and OMB Bulletin 93-06 is not designed to determine HCFA's readiness for Year 2000. Further, we have no responsibility with regard to HCFA's efforts to make its systems, or any other systems, such as those of HCFA's vendors, service providers, or any other third parties, Year 2000 ready or to provide assurance on whether HCFA has addressed or will be able to address all of the affected systems on a timely basis. These are responsibilities of HCFA's management.

The results of our tests disclosed instances in which HCFA's financial management systems did not substantially comply with some of the requirements discussed in the second preceding paragraph. The *Report of Independent Auditors on Internal Control* includes information related to the financial management systems that were found not to comply with the requirements, relevant facts on the noncompliance, our recommendations related to the specific issues presented, and relevant comments from HCFA management responsible for the noncompliance, including management's proposed action plan. These instances of noncompliance relate to accounting and EDP systems at the HCFA central office and at Medicare contractors and are presented below:

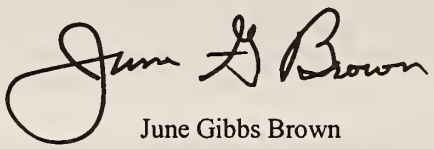
- The HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level.

- The HCFA's process for preparing annual financial statements is manually intensive, involving a series of spreadsheets that incorporate general ledger data as well as Treasury information, contractor information, and adjustments determined by HCFA.

- The HCFA central office and Medicare contractor access and application control weaknesses are significant departures from requirements in OMB Circulars, A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

This report, which incorporates HCFA's informal comments where appropriate, is intended for the information of HCFA, the Secretary, and OMB. However, this report is a matter of public record, and its distribution is not limited.



June Gibbs Brown
Inspector General
Department of Health and Human Services

Glossary

Chapter 5

Glossary

Accrual Accounting : An accounting technique that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable on determining annual income.

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA (e.g. salaries and expenses, facilities, equipment, rent and utilities, etc). These costs are reflected in the Program Management account.

Balanced Budget Act of 1997 (BBA): Major provisions include the Children's Health Insurance Program, Medicare+Choice, and expansion of preventive benefits.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

Benefit Payments: Funds outlayed or expenses accrued for services delivered to beneficiaries.

Carrier: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay physician and supplier claims.

Cash Accounting: An accounting basis that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred. Revenues and expenses are recognized when cash is received or disbursed. There are no accruals.

Children's Health Insurance Program (CHIP) (also known as Title XXI): This is a provision of the BBA that provides federal funding through HCFA to States so that they can expand child health assistance to uninsured, low-income children.

Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Durable Medical Equipment Regional Carrier (DMERC): A company that contracts to pay Medicare claims for purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Demonstrations: Projects and contracts that HCFA has signed with various health care organizations. These contracts allow HCFA to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

Expense: An outlay or an accrued liability for services incurred in the current period. This term is used to show accrual accounting.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

Federal Insurance Contribution Act (FICA) Payroll Tax: Payroll-based taxes that are used to fund the Social Security and health insurance trust funds. In FY 1997, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

Federal Financial Management Improvement Act (FFMIA): Legislation that requires financial agencies to comply substantially with Federal financial management systems requirements.

Federal Medical Assistance Percentage (FMAP): The portion of the Medicaid program which is paid by the Federal government.

Federal Managers' Financial Integrity Act (FMFIA): A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

Government Management and Reform Act (GMRA): Legislation that requires a government-wide audited financial statement.

Government Performance and Results Act (GPRA): Legislation that require agencies to develop performance measures and an annual performance plan for FY 1999, and an accountability report in the year 2000.

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Includes portability provisions for group and individual health insurance, the establishment of the Medicare Integrity Program, and provisions for standardization of health data and privacy of health records.

Hospital Insurance (HI): The part of Medicare that pays hospital and other institutional provider benefit claims. See "Part A."

Information Technology (IT): The term commonly applied to maintenance of data through computer systems.

Intermediary: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as Management controls.

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management or internal controls requiring high-priority corrective action.

Medicare Current Beneficiary Survey (MCBS) : A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

Medicare Contractor: A collective term for carriers and intermediaries.

Medicare+Choice: A provision in the BBA that restructures HCFA's authority to contract with a variety of managed care entities, including health maintenance organizations (HMO) and Competitive Medical Plans (CMP), both of which were previously allowed to participate in Medicare, as well as preferred provider organizations (PPO) and preferred supplier organizations (PSO), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts (MSAs), for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

Medicare Integrity Program (MIP): A provision in HIPAA that sets up a revolving fund to support HCFA's program integrity program.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

MR/UR (Medical Review/Utilization Review): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

Medicare Secondary Payer (MSP): A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Obligation: Budgeted funds committed to be spent.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits. Used for cash accounting.

Part A: The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or "HI."

Part B: The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or "SMI."

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

PRO (Peer Review Organization): PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

Program Management: HCFA's operational account. The Program Management appropriation supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization providing medical services.

Recipient: An individual covered by the Medicaid program, however, now referred to as a beneficiary.

Risk-Based Health Maintenance Organization (HMO)/ Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should

the Medicare enrollee/ member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

Self Employment Contribution Act (SECA) Payroll Tax: Medicare's share of SECA is used to fund the HI Trust Fund. In Fiscal Year 1997, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Supplementary Medical Insurance (SMI): The part of Medicare that pays physician and supplier claims. See "Part B."

Tax and Donations: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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